

W2
A2
9F 2193

~~TOP SECRET~~ RESTRICTED

(DOCUMENT SECTION)

THE SURGEON'S

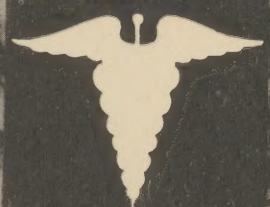
Circular Letter

1 JULY 1951

VOLUME • VI
NUMBER • 7



A FAR EAST
PERIODICAL



OF ARMY
MEDICAL SERVICES
INFORMATION

MEDICAL SECTION • GHQ • FEC, SCAP AND UN

APO 500

RESTRICTED



Wounded soldiers are loaded aboard hospital train headed toward rear



Casualty is lifted onto tank of 9th Infantry Regt, 2d Division, for evacuation to nearby aid station



Capt Charles Caley (left), dental officer with 38th Regt, at Coll Sta



A shipment of whole blood is delivered to medical depot in Korea



Puerto Rican soldier is given first aid by company aid men of 65th Regt



Med of 3d Medical Battalion remove injured soldier from ambulance at Div Clearing Sta



Maj Catherine Jump (now at Tokyo Army Hosp), talks to orphans who "adopted her" in Taegu



U.S. and Danish personnel confer aboard hospital ship "Jutlandia"



Cpl J. Mirabella treats civilian casualty, aided by girl's father

On the cover

A painfully wounded Chinese prisoner is given first aid by medical technicians of the 65th Regimental Combat Team, U. S. 3rd Infantry Division on the East Central Front. All photographs are from U. S. Army Signal Corps unless otherwise stated.

Circular
Letter

Volume VI - Number 7

1 JULY 1951

General Headquarters
Far East Command
Medical Section
APO 500

ADMINISTRATIVE

PHW Section, SCAP, Discontinued.	121
General Armstrong Sends Thanks to FEC Medical Personnel.	121
Surgeon's Circular Letter Expands in Size and Circulation.	122
UN Hospital Ship "Jutlandia"	122
Biennial International Congress of Military Medicine Held in Paris	123
Awards to Army Medical Service Personnel	124
Conservation of Supplies	125
Medical Regulating Officer	126
Recent Department of the Army Publications	127
Preview of New Monthly Dental Report	127
Register of Dental Patients.	129
Oxygen Unit Adapted for Litter Use	129
The Hospital Command Team.	129
Chinese Wounded Given Same Medical Care as UN Personnel.	131

PUBLIC HEALTH AND WELFARE SECTION, SCAP DISCONTINUED; REPLACED BY MEDICAL SECTION, GHQ, SCAP

The Medical Section, General Headquarters, SCAP, has been established as a special staff section to advise the Supreme Commander on policies and programs relating to public health and welfare problems in Japan. Major General Edgar Erskine Hume will head the new section as Surgeon, GHQ, SCAP, in addition to his present assignment as Chief Surgeon, GHQ, FEC.

Concurrent with the establishment of the special staff section is the announcement of the discontinuance of the Public Health and Welfare Section, which had been established in 1945 as a SCAP section. Personnel, records, responsibilities and functions

of PH&W Section are transferred to the Medical Section, GHQ, SCAP.

Colonel C. S. Mollohan, MC, will function as Chief, Public Health and Welfare Division, Medical Section, SCAP. Colonel Mollohan had served briefly as Chief of PH&W Section, succeeding Brig. Gen. Crawford F. Sams, who returned to the United States recently.

Since September, 1947, Colonel Mollohan had served as Deputy Surgeon under General Sams. Prior to that time he was assigned to the Harvard School of Public Health. During World War II, Colonel Mollohan served in the European Theater.

GENERAL ARMSTRONG SENDS THANKS TO FEC MEDICAL PERSONNEL

The following message from Major General George E. Armstrong, newly appointed Surgeon General, was received by Major General Edgar Erskine Hume, Chief Surgeon, GHQ, FEC, and GHQ, SCAP.

"I should like to take this opportunity of thanking you, and all of the commissioned and enlisted medical personnel of the Far East Command and the United Nations Command in Korea for the very splen-

did affirmation of loyalty and support as contained in the cablegram sent me on 1 June.

It is indeed a source of great satisfaction and contentment to know that during the troubled years ahead the cooperation which has been so willingly given in the past will continue, unquestionably.

With heartfelt thanks to you all."

SURGEON'S CIRCULAR LETTER EXPANDS IN SIZE AND CIRCULATION

Approval has been granted by the Printing Control Committee, Chief of Staff, GHQ, FEC, for an "as needed" increase in the number of pages of the SURGEON'S CIRCULAR LETTER, effective with this issue.

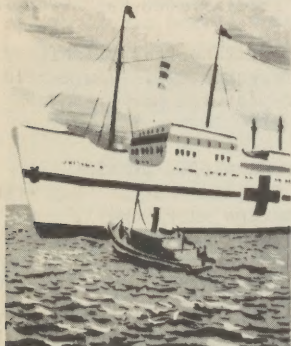
A restriction to 20 pages placed in 1946 has been relaxed to allow for a greater flexibility in preparing the publication. Heretofore, many worthwhile articles were unavoidably rejected, held indefinitely or condensed because of space limitations. It is hoped that medical personnel will avail themselves of this greater opportunity to share their professional experiences with others.

Circulation has been expanded to compensate for the

increased number of Army medical personnel now on duty in the Far East Command. In addition, an effort is being made to reach as many Far East Air Force, Naval and other UN medical officers as possible. Direct distribution will be made to all major FEAF and Navy medical installations.

Approval for medical personnel of these branches to contribute material for publication has been granted by the Surgeon, FEAF, and the Force Medical Officer, COMNAVFE. There is no doubt that Air Force, Naval and other UN medical officers possess a wealth of information that would be read with great interest by other members of their profession. Their contributions are sincerely invited.

UNITED NATIONS' HOSPITAL SHIP "JUTLANDIA" VISITS JAPAN



The Danish hospital ship Jutlandia recently returned to Japan from Korea carrying several hundred United Nations wounded. Personnel of the ship, under command of Commodore Kai Hammerich of the Royal Danish Navy and former president of the Danish Red Cross, took a brief respite from nearly three months of continuous medical service aboard the

floating hospital in Korean waters.

According to Capt. Andres George, Copenhagen, public information officer of the hospital ship and a correspondent for Denmark's newspapers and radio stations, the Jutlandia would soon return to the Korean campaign on her mission of mercy.

"But until we sail, we're going to take it easy for a few days," he said. "You know, there's no such thing as rest and regular hours when you're caring for wounded, and we haven't had much chance for recreation in Korea."

Chartered from the East Asiatic Company by the Danish Government one month after the outbreak of the Korean war, the Jutlandia, a cargo-passenger vessel sailing between Copenhagen and New York, was converted before the end of the year to a modern, well-equipped hospital ship. The government of Denmark appropriated nearly \$1,000,000 for the conversion of the 8,500 ton vessel and an additional \$2,000,000 to pay for medicine, supplies, equipment and maintenance costs.

Pledged by Denmark to serve at least one year in support of the Korean campaign, the Jutlandia joined United Nations forces in the Far East early in March. In the three months since its arrival the Danish medical contingent has handled more than 1,200 seriously or critically injured UN soldiers and has already compiled an impressive record of successful major surgical operations.

"There have been very few fatalities among serious-

ly wounded patients evacuated from the fighting front to the Jutlandia," said Captain Georg. "We have done everything humanly possible to save the lives of all United Nations wounded who are placed in our care."

The 100 persons who comprise the hospital staff, including 16 doctors, 40 nurses, 25 orderlies, 1 chaplain and other administrative and technical assistants, are all civilian volunteers chosen by the Danish Government from more than 3,000 applicants. The individuals selected represent some of the best medical talent available in Denmark. All have had prior military training since service in the Danish Army is compulsory.

Heading the list of surgical specialists now serving aboard the Jutlandia is Professor Edward Busch, one of the foremost brain surgeons in the world. Of equal international fame is Dr. Tage Kjeear, whose accomplishments in difficult chest surgery have gained world-wide recognition.

Captain Georg stated that 85% of the casualties treated aboard the floating hospital are American. The remainder are troops from all other UN forces engaged in the Korean fighting.

"Wounded are evacuated to our hospital by air or train from the front," he said. "Some arrive within five or six hours from the time they are hurt but normal evacuation time is 24 hours. The injured soldiers have been given first aid and perhaps have undergone some prior surgery at advance field hospitals before they are brought aboard."

Patients requiring brain or chest surgery are retained for five or six days following operations and are then sent to Japan or on to their homeland for further treatment and recuperation. Minor surgical cases, however, remain on the ship until they have recovered and are returned to their units.

The Jutlandia is equipped with three operating theaters, including one for general surgery. She is fitted with two modern laboratories, a dental clinic, X-ray laboratory, pharmacy, laundry, kitchen, bakery, tailor shop and barber shop. There is, in addition, a well-stocked PX for the patients and members of the hospital staff with a diversified assortment of both necessities and luxury items.

Normally a 300-bed hospital, the Jutlandia can in emergency accommodate twice that number of patients. Wards, located in the ship's holds, are completely modern. The more serious surgical cases, however, are cared for in private rooms on the cabin deck. Quarters for the medical personnel also are located in small, though comfortable and neatly furnished, deck cabins.

Captain Georg, explaining Denmark's offer of the Jutlandia to the United Nations, said: "We are now members of the United Nations and the North Atlantic Treaty Organization and wished to fulfill our obligations. Since we couldn't spare military units, because of our commitments to NATO, our government decided to furnish and equip the Jutlandia and in this manner contribute to the success of United Nations forces in the Korean war."

Though the Jutlandia's personnel are all civilians, doctors are addressed as colonel and all staff members as captain. "That's probably due to our previous military training," Georg explained. "In any case, we've certainly learned a lot here. In our humble way we are not only helping the cause of the United Nations, but also are reaping the benefits of valuable practical training and experience in handling war surgical cases."

"One thing that has impressed all of us is the wonderful morale of the wounded. They never complain. They're usually pretty tired when they arrive and spend their first few days aboard sleeping. They react well to our treatment and when they're informed by the doctors that an operation is necessary, they grin and say, 'OK, doc - let's get the show on the road.'"

"Cooperation given our staff by American doctors has been exceptional," Georg continued, "and we frequently exchange personnel for difficult operations. For example, we have no eye specialist aboard, while the American hospital ships do. In cases where such a specialist is required we ask one of their men to help us out and, of course, they call on us occasionally for delicate brain or chest surgery. It's a wonderful working arrangement."

Captain Georg said the Jutlandia also served as a medical classroom for visiting Korean doctors. "Many times we have had Korean doctors present in the operating theaters to observe the surgical skill of Professor Busch, Dr. Kjeor or some of our other specialists. Following an operation, a clinic is held in which the case is reviewed and the surgery discussed. The Koreans are avid students," he added.

Georg said that all the patients seemed to enjoy Danish food aboard ship. "Even the Koreans, who at first want only rice, soon go on a full Danish diet. They watch other patients hungrily devouring the food we serve and I guess they just can't help themselves." As to the GIs' response to care tendered by the bevy of good-looking Danish nurses aboard the Jutlandia, Georg remarked: "A woman's touch does wonders! And it's usually not long before the men try to pick up a few Danish words just so they can impress the nurses who take care of them."

"Music also helps a wounded soldier recover," he said. "We have an American Red Cross field director aboard who sees to it that those who are musically inclined are provided instruments for recreation. You should have heard the Greek soldier play the harmonica she gave him; he was terrific!"

Language differences are somewhat of a problem on the Jutlandia, according to Captain Georg. "But with the aid of interpreters we manage fairly well," he said. "All our people speak English, which helps considerably since most of the wounded do, too."

Many of the ex-patients have written grateful letters to the staff of the Jutlandia thanking them for their wonderful treatment. "One wrote that he was going to have his dog tags engraved: 'When wounded again, please send me back to the Jutlandia.' That soldier evidently liked our care," he concluded.

Captain Georg, who speaks English with a marked British accent, although educated in Denmark, is married to an American girl he met in Europe last year. She is now living in Copenhagen awaiting his return.

BIENNIAL INTERNATIONAL CONGRESS OF MILITARY MEDICINE HELD IN PARIS

Delegates from fifty countries attending the 13th International Congress of Military Medicine held in Paris, 17 - 28 June, were told of the medical aspects of the Korean campaign by Major General Edgar Erakine Hume, Chief Surgeon, GHQ, FEC. General Hume, who has been the U. S. member of the International Committee for 25 years, demonstrated to the assembly medical equipment and uniforms used by United Nations troops and showed many photographs of medical installations, evacuation and treatment in Korea.

The International Congresses of Military Medicine were established in 1922 by Albert, King of the Belgians, and except during World War II, have met every other year since that time. Their purpose is to maintain throughout periods of peace the knowledge and techniques of military medicine learned during war times.

This year's meeting was held at the historic Val de

Grace, the French Army's medical center in Paris. Those in attendance found the site particularly well-chosen, for 1951 marks not only the 100th anniversary of the Val de Grace, but also the 2000th anniversary of the city of Paris.

American delegates, in addition to General Hume, included Maj. Gen. George E. Armstrong, Army Surgeon General; Maj. Gen. Harry G. Armstrong, Air Force Surgeon General; Vice-Admiral Joel T. Boone, Medical Director of the Veterans Administration; Maj. Gen. Guy B. Denit, Chief Surgeon, European Command; and Brig. Gen. Isador S. Ravdin, Reserve.

They were received by President Auriol of the French Republic, M. Mock, Minister of Defense, and others.

Montevideo, Uruguay, was selected as the meeting place for the 1953 Congress.

AWARDS TO ARMY MEDICAL SERVICE PERSONNEL

The following additional Army Medical Service personnel have been awarded the Distinguished Service Cross, Silver Star, Legion of Merit, Soldier's Medal, Bronze Star Medal, or Commendation Ribbon for exceptional bravery in face of the enemy and meritorious service during the Korean conflict.

Distinguished Service Cross

Nall, Raymond E., Cpl

Silver Star

Bates, Roy L., 1st Lt, MSC
Brown, Stanley A., SFC
Charlo, Peter A., Cpl
Christenson, Charles, Cpl
Cotton, Jack L., Sgt
Dewitt, James D., Sgt
Dovell, Chauncey E., Col, MC
Drowns, Norman S., Capt, MSC
Evans, Louis A., M/Sgt
Hall, Robert M., Capt, MC
Heath, Mayo S., 1st Lt
Hoover, Maryland, Cpl
Hubbard, John E., PFC
Huebner, George Jr., Sgt
Jensen, Robert T., Capt, MC
Johnson, Howard E., Cpl
Josey, William J., M/Sgt
Levy, Harold, PFC
Mandsen, Everett, Sgt
McFarland, Floyd, Sgt
Miller, Edward M., Cpl
Pepin, Daniel F., Cpl
Petrea, John H., Cpl
Rameriz, Alejandro, Cpl
Riley, Michael J., Sgt
Rodriguez, Pacheco, Cpl
Rowland, John M., Cpl
Ryan, Edwin W., Cpl
Scalf, Jack R., Cpl
Thompson, Allen T., 1st Lt, MSC
West, James C., Sgt
Woodley, Perry F., PFC

Legion of Merit

Desmond, Madeline M., Lt Col, ANC
Hullingerhorst, Robert, Lt Col, MC
Meirowsky, Arnold M., Lt Col, MC
Strode, John T. B., Col, MC
Vickoren, Angvald, Col, MC
Walker, Herman A., Lt Col, MSC

Soldier's Medal

Foster, Howard L., Sgt

Bronze Star Medal

Abrams, Joseph T., 1st Lt, MSC*
Anderson, Roy L., Cpl
Arnette, Robert P., Cpl*
Austin, Leroy P., SFC
Banks, Leroy Jr., Cpl
Barbie, John N., 1st Lt, MSC
Barron, Thomas S., Maj, MC
Bates, Roy L., 1st Lt, MSC
Begen, Frank R., Capt, MC
Berry, James R., Sgt
Betts, Wilmer C., Capt, MC
Biggs, Harold J., Sgt*
Black, Paul J. Jr., Cpl*
Blackwell, William, M/Sgt*

Bonaparte, Charles, PFC
Bond, Marcus B., Capt, MC*
Bond, Robert T., PFC*
Booher, David O., Capt, MC
Boucher, Wilfred A., PFC
Britto, Domingo, Cpl
Brown, Clarence, Capt, MC
Bruns, William F., Pvt
Bunger, Egbert V., Capt, MSC
Burns, Donald C., Cpl*
Campbell, Everett C., Cpl*
Campbell, Gilbert S., Capt, MC*
Capsey, Norman T., Capt, DC
Caskie, James D., Maj, MC
Cennamo, Sebastian, 1st Lt, MSC*
Chapman, Ralph R., Maj, MC
Chavez, Mario, Cpl
Cineros, Dionisio, Sgt*
Claiborne, Robert, Sgt
Clark, George A., 1st Lt, MC
Clark, Howard, 1st Lt, MSC*
Cloud, Hamilton S., Capt, DC
Coleman, Arthur J., M/Sgt
Collier, William H., PFC
Collins, Glenn J., Lt Col, MC
Commins, George J., Sgt*
Connell, Florence T., Capt, ANC
Couch, Inez, Capt, ANC
Cronin, John A., Capt, MSC
Crosby, Ernest G. Jr., 2d Lt, MSC
Dagley, Hubert R., Maj, MC
Dasent, Eugene M., Maj, DC
Davis, Harold M., Pvt*
Dibble, William L., PFC*
Dickey, Leland D., PFC
Downing, Jack W., Capt, MSC
Dudkowski, George W., PFC*
East, Gilbert L., Maj, MSC
Edginton, Roy D., Cpl
Edwards, James T. Jr., Cpl*
Eplin, James L., Sgt*
Erickson, Kenneth A., Cpl*
Ess, Earl D., 1st Lt, MSC
Faison, Thomas G., Col, MC
Fiske, Gustav H., Sgt*
Fittery, Herman A., M/Sgt
Franklin, David, Cpl
Galvan, Guadalupe, PFC*
Gardner, Robert, 2d Lt, MSC*
Gillus, Edward G., Cpl
Goddard, Wilbur R., Cpl
Gorski, Lucyan H., SFC
Griffin, Leroy, PFC
Grote, Raymond H., Sgt*
Guidroz, Severn E. Jr., Sgt*
Gunn, Julian C., Cpl*
Gutierrez, Rudolpho, Cpl*
Halsing, Alvar M., PFC
Hamilton, Joseph F., PFC*
Hammer, Jack H., PFC
Hancock, William, Maj, MC
Harmeling, Harold F., Sgt*
Harrah, James T., SFC*
Harris, Bory M., 1st Lt, ANC
Harris, John L. Jr., Capt, MC
Harrison, James L., Sgt
Harsh, Griffith R., Capt, MC
Hart, Marvin J., Cpl*
Hayes, James E., Maj, MSC
Heard, John P., Capt, MC

Heaton, Jack H., Cpl*
Hedgepath, Leslie E., Capt, MC
Hickman, Harold C., Cpl
Higa, Susumu, Sgt
Hile, Charles E., Sgt*
Hill, Samuel O., Lt Col, MSC
Holbrooks, George M., Sgt*
Holloway, Hurley L., Cpl
Hudson, Eddie F., Sgt
Hurley, Thomas J., Capt, MC
Irvin, Robert W. Jr., Capt, MC
Johns, Floyd W., Sgt*
Johnson, Arnold Jr., Capt, MC
Johnson, Jack R., PFC
Johnson, Troy, Sgt
Jones, Edward, M/Sgt*
Jones, Ralph L., Cpl*
Kellerman, Robert C., Sgt
Kidwell, Ercel C., Pvt*
King, Charles D., 1st Lt, MSC
Knapp, Jack T., Cpl*
Kowallek, Paul J., Maj, MC
LaPage, Robert A., Sgt*
Laffitte, Herbert B., Maj, DC
Lane, Thomas H., Lt Col, MC
Laraouente, David, Cpl*
Larsen, Leslie R., Sgt
Leal, Archie, PFC*
Lebron, Rodriguez G., PFC*
Lema, Antone, Cpl*
Lemay, Edward F., 1st Lt, MSC*
Levanduk, Walter, Sgt*
Levesque, Paul M., Maj, MSC
Lewis, Roosevelt, Cpl
Lopez, Patricio, PFC
Lopez, Salvador, Cpl*
Lordi, George D., Cpl*
Macri, Joseph F., Cpl*
Madden, Mary J., Capt, ANC
Markowitz, Isidor, Lt Col, MC*
Mathews, Thomas O., Maj, MSC
Maxson, Paul A., 1st Lt, MSC
Maynard, McKenly, Jr., Cpl*
McBrayer, Howard A., PFC
McCorkle, Benjamin, Sgt
Mendoza, Jose, PFC*
Miller, Emery C. Jr., Capt, MC
Miller, Eugene A., Cpl
Milican, Marvin G., Sgt*
Millwood, Adrian T., PFC
Miranda, Victor M., Cpl*
Miskelly, Paul R., Cpl*
Moa, John A., Capt, MSC
Monsey, Tommy H., Sgt
Moore, Jessie E., Cpl*
Moore, William C., Sgt
Morasco, Patsy J. J., Sgt*
Moreland, J. L., Capt, MSC
Morrison, Frederick, M/Sgt
Morrow, James W., Sgt*
Murray, Charles H., Sgt
Myers, Melvin E., Cpl
Nowlis, Gerald R., Capt, MC
O'Neal Cecil S., SFC
O'Neill, Irvin J., Cpl*
Parish, Dean L., SFC
Patalo, Angelo M., PFC*
Patterson, John C., Lt Col, MC
Patterson, James Jr., Capt, MC
Perez, Victor M., PFC*

Pettus, George G., Jr., Sgt*
 Pevey, William N., SFC
 Pfotenhauer, Martin, Maj, MC
 Poole, Herman L., 1st Lt MSC
 Pugh, Othal L., Sgt
 Ransome, Benjamin T., PFC
 Reed, Theodore J., Cpl*
 Reeves, Orval J., Cpl*
 Reiter, Arthur W., Capt, MC
 Remund, Donald E., Lt Col, MSC
 Reynolds, Robert G., SFC
 Richardson, Rex A., Sgt
 Riley, John J., 1st Lt, MC*
 Ritter, Richard E., Cpl
 Rivera-Aponte, Greg, Cpl*
 Rivera, Victor R., Capt, MC*
 Roach, Leonard W. Jr., Pvt
 Robbe, Alice J., Lt Col, ANC
 Rogers, George E., Sgt*
 Rogers, K. C., PFC*
 Ruskowski, Henry J., Sgt*
 Samura, Manabu, Cpl*
 Sanchez, Arnold R., 1st Lt, MC
 Schoneboom, Herman, Cpl
 Serafino, Carman J., Sgt*
 Serfas, Lee S., Maj, MC
 Shafer, James W., Capt, MSC
 Sharp, James M., PFC
 Shealor, Ralph R., Cpl
 Sheets, William M., PFC
 Shenk, Patrick H., Cpl
 Shirai, Takeshi, Sgt
 Short, Marion, Sgt*
 Smith, Rachel H., Capt, ANC
 Snowden, Robert C., Capt, DC
 Snyder, Charles F., Capt, MC
 Stacey, Richard M., Capt, MSC
 Stergiades, Theodore, Capt, MC
 Stewart, Charles H., Cpl*
 Stith, John R., PFC
 Stroud, Joseph C. Jr., Maj, MC

Talley, Clifton P., Lt Col, MSC
 Tarver, James W., Col
 Tello, Arnulfo, Cpl*
 Thomas, Charles A., PFC
 Thomas, Herman E., Sgt*
 Tipton, Ralph E., M/Sgt
 Tucker, Alfred N., Capt, MSC*
 Tuscher, David A., Sgt*
 Wade, John F. Jr., Sgt
 Walker, Keith A., Maj, MC
 Walsh, Joseph T., 1st Lt, MSC
 Warren, Arthur, 1st Lt, MSC
 Wartonick, Walter, Capt, MC
 Watson, Ruth V., Capt, ANC
 Weatherall, Richard, Capt, MSC
 Weber, Barrett H., Capt, MC
 Weber, William H., Capt, MC
 Werth, Dee A., Cpl*
 Wheatley, Robert, Cpl
 White, Morris, Cpl*
 Whitley, Fenner H. J., Lt Col, MSC
 Whitmore, William H., Capt, MC
 Wilkins, Truman, PFC*
 Williams, Bernard C., Cpl
 Wright, Lloyd B., Sgt*
 Yager, Isadore, Capt, MC
 Yarbrough, Charlie, Cpl
 Yeakey, Albert, Sgt
 Yongstrom, Karl A., Maj, MC
 Zolenas, Anthony J., Lt Col, MC

*(Bronze Star Medal with "V" Device)

Commendation Ribbon

Beers, Donald B., M/Sgt
 Benner, John F., 1st Lt, MSC
 Berrier, March M., M/Sgt
 Blemly, Nelson R., Capt, MC
 Boyer, Stanard D., Sgt
 Branum, Leon C., SFC

Bunnell, James B., Maj, DC
 Burke, Daniel F., Sgt
 Carey, Wallace C., M/Sgt
 Chambers, Rex K., Cpl
 Chastain, Arthur R., PFC
 Collins, Fred J., Sgt
 Davis, Vilas L., Sgt
 Delosier, Robert M., Sgt
 Dimmick, Ivan C. Jr., Lt Col, MC
 Dreisback, Robert F., Capt, MSC
 Erdman, Albert R., SFC
 Ford, Francis W., Cpl
 Gray, Glen D., SFC
 Hall, Blount J., Sgt
 Hixon, Harold W., Sgt
 Hughes, Rosamond E., Capt, WMSC
 Ibay, Enrique C., Cpl
 Kimball, Cecil H., Capt, MC
 Lenze, Gladys L., Maj, ANC
 McCord, Richard F., SFC
 Mesch, Fred P., M/Sgt
 Miller, Rimmel T., Cpl
 Moses, Eva P., Capt, ANC
 Nelson, William A. J., Maj, MSC
 Novosad, Jerry J., M/Sgt
 Onaga, Eiko R., Cpl
 Palmer, Laverne, Cpl
 Pappas, John P., SFC
 Jarvi, Rudolph M., Capt, MC
 Quarantillo, Edward, Lt Col, DC
 Schoenfield, Anton, M/Sgt
 Sellman, Russell D., Sgt
 Swift, Teddy E., SFC
 Topfer, Kimmet, 1st Lt, MSC
 Trump, Howard R., Sgt
 Von Bergen, Ralph W., Sgt
 Wallner, Margaret D., 1st Lt, ANC
 Ward, Lorne James, Cpl
 Wilsor, Dennis R., SFC
 Woodstock, Charles, M/Sgt
 Yeakel, Roy J., Capt, MSC

CONSERVATION OF SUPPLIES

Supply and Fiscal Division, Medical Section, GHQ, FEC

A recent directive from the Department of the Army requires that Inspectors General devote particular attention to supply economy during the Fiscal Year 1952. It points out that supply economy as a main effort is particularly appropriate at this time because of the expansion of the National Defense Program, and the attendant burden on national production facilities.

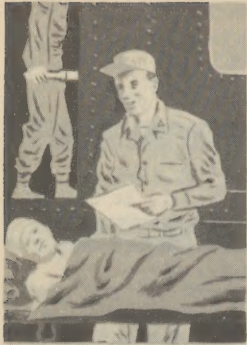
In the medical supply field, certain shortages have already developed due to a shortage of raw material and overburdened production facilities. Unless a maximum effort is made to economize on the use of medical materiel, some items now in short supply will be completely out of stock for long periods of time. Lists of critical items are regularly furnished each major command by the Department of the Army. The list at this time of metal, rubber, textile, chemical, and drug items, is already too long to permit inclusion in the space available in this publication. It is suggested that the Commanding Officer of each medical organization become completely familiar with current listings of items in short supply and give them wide publicity in his organization.

Continuing surveillance should be made by the Commanding Officer and the Chiefs of Professional Serv-

ices in their daily rounds of the installation or activity as to the practice of economy in the use of medical materiel. It is not desired that any medical activity be denied medical items for proper use in the care and treatment of the sick and injured. However, extreme care should be taken to prevent waste through extravagance or misuse. The many and varied uses to which some medical items may be misapplied are too numerous to mention, and are usually quite well known to all concerned.

The responsibility of the Commanding Officer in the use and care of Government property is a personal one and may not be delegated. The administrative duties of the Supply Officer are detailed in regulations and include inelastic provisions regarding his liability for negligence or misuse.

It is the desire of the Chief Surgeon that each member of the Army Medical Service of the Far East Command assume his share of the responsibility for conservation and proper use of the supplies and equipment furnished. Materiel on hand and not needed for immediate use should be turned in to the proper supply agency. Without complete and proper utilization of the medical assets available, the medical supply system will be unable to furnish all essential requirements.



MEDICAL REGULATING OFFICER OR SCREENING PROCESS IN PUSAN, KOREA
Lt Colonel Vincent J. Amato, MC, 52d Medical Battalion, APO 301

The excellent care of combat casualties characteristic of American military operations depends not only on suitable planning of medical installations and transportation, but also on proper screening. Screening gives to a Medical Regulating Officer the responsibility for sorting and evacuating casualties; by quick and

high quality of judgment, he must recognize the nature of the injury in order to assign the wounded to the proper hospital for specific treatment.

Before attempting to screen patients, it is essential to become thoroughly familiar with the following:

1. All directives from the Army Surgeon's Office pertaining to the distribution of casualties, including wounded POWs. A directive by the Army Surgeon is furnished to guide the Medical Regulating Officer in the screening and hospitalization of casualties. It is this directive that furnishes the main and most important outline for allocation of patients in order to facilitate the prolonged care for some and the expeditious return to duty of others.

2. The specialties and facilities existing in the various hospitals. It is well to interview the Commanding Officers of all hospitals in order to determine the particular type of cases their staffs are qualified to treat or may be interested in. The Medical Regulating Officer should be informed of any change in the specialist staff of a hospital. An aid in screening is the preparation of a list of surgical and medical diagnoses, each earmarked for the specific hospitals prepared to take care of these special cases. A list is also kept of certain facilities available in the various hospitals, such as eye magnet for removal of metallic foreign body, iron lung, EKG, basal metabolism apparatus, bronchoscope, cystoscope, etc.

3. The languages which are spoken in the various hospitals. Language should be no great barrier, for the surgeon relies on objective findings. But when possible the UN soldier is best sent to a hospital to which an interpreter or nurses from his own country are assigned. A list is kept of interpreters available in the hospitals for various languages spoken among units of the UN Army.

4. The daily record which is kept of the vacant beds available and the number of ambulatory and litter cases which are allocated to the various hospitals. This record insures as even a distribution as possible.

Screening is sometimes done hastily by accepting the diagnosis on the jacket (Form 8-28), but if it is to be done properly it will require a little more time and care. This requires examining the EMT (Form 8-26) or Field Medical Record (Form 8-27), to determine the type of wound or nature of illness, nerve or artery involvement, injury to the spinal cord, LOD status, or any NP condition. It is important to know the LOD status for if it is undetermined, the case is referred to designated U. S.

Army hospitals where the necessary data are recorded. The same is true for injuries incurred as a result of accidents, when further investigation is required. Occasionally a soldier may have two diagnoses, one medical, the other psychiatric. Whenever there is an NP diagnosis, the case is assigned to a hospital which has a psychiatrist in attendance. Certain cases may be directed to special centers for immediate evacuation to the ZI.

The patients may arrive by plane or train. Those arriving by train come from mobile surgical units, evacuation or field hospitals and are accompanied by a medical officer and a nurse who are familiar with each case and thus aid in expediting the screening. Upon arrival of the train, the seriously ill or wounded who require immediate care are removed without delay and transported to the nearest available hospital or to the one necessary for special surgery. Next, the number of ambulatory and litter cases are determined. They are segregated into several categories: Army, Marine and UN; litter and ambulatory; contagious diseases, and the POWs. Usually this is known before the arrival of the hospital train and it gives the Medical Regulating Officer time to determine the approximate distribution of the cases, and the Operating Officer opportunity to provide for adequate transportation. The ambulatory patients are screened first because it makes for easier evacuation of the litter cases. They are immediately transferred to ambulances or buses designated for specific hospitals. The majority of the ambulatory are "holding" cases, a particularly selected group of lightly wounded. Under the general plan they are sent to designated hospitals so that they may be readily treated and returned to general duty status within reasonable time. The Regulating Officer should be on the alert for any ambulatory patient who appears weak or who has a wound or a fracture that makes transportation by litter advisable. In screening the litter cases, the medical officer and nurse on board the hospital train accompany the Regulating Officer and brief him as to the diagnosis and complications of each casualty. These litter cases are distributed according to the special surgery necessary. All penetrating wounds of the heads, neck, involvement of the spinal cord, and brachial plexus are sent to the neurosurgeons. Thoracic, abdominal, GU wounds, orthopedic cases, fractures of the mandible or maxilla are evenly distributed to designated hospitals. For example, if there are six penetrating wounds of the chest and three hospitals with thoracic surgeons, then two cases are sent to each; this expedites these special cases and avoids overloading any one surgeon. Those with contagious diseases are screened last and transferred in separate ambulances according to the diagnosis in order to avoid further contact with the sick and wounded. Casualties arriving by plane come directly from clearing stations or mobile surgical units and are removed to a holding company until they are transported by rail or ambulance to the nearest hospital. The holding company may be a distance of ten miles or more of bad roads from the nearest hospital. A shuttle run of litter buses on rail or hospital trains is essential to transport the casualties comfortably. Any prolonged stay at the holding company tends to defeat the purpose of rapid evacuation by air. At the holding company the following are recommended: (1) A check of all patients' medical records. In any cases in which there are no medical records, a duplicate EMT (Form 8-26) should

be immediately made out; the importance of this is obvious in the seriously wounded. (2) A check of all the wounds. If any dressing has come off in transit a new one should, of course, be applied. (3) When the casualties from the clearing station are arriving by plane at the holding company in great numbers, it is advisable to have a medical officer and a nurse at the station. The decision to give morphine, plasma, or blood transfusion is one that rests with a medical officer and could be a life-saving factor.

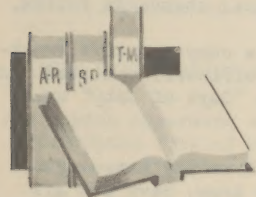
CONCLUSION:

Screening calls for careful planning and consideration: (1) To assign the sick and wounded to "existing medical facilities according to their ability

to render care required." (2) To allocate the slightly wounded and disabled to designated hospitals in order to conserve time and personnel and expedite the return to duty. (3) To distribute all accidents and undetermined LOD cases to U. S. Army hospitals so that the special procedures and necessary data can be properly recorded. (4) To distribute the casualties as evenly as possible in order to avoid overloading any one particular hospital according to the existing bed vacancies.

Screening, then, is projected to give the best treatment to the individual by careful selectivity of the casualty by a Medical Regulating Officer. It also makes for saving of time and effort which is particularly desirable in handling the casualties, both in the interest of the soldier and the service.

RECENT DEPARTMENT OF THE ARMY PUBLICATIONS



- AR 140-140, C-4, 16 May 51: Organized Reserve Corps - Assignments and Attachments
- AR 40-35, 21 May 51: Medical Service - Appointment, Duties and Responsibilities of Professional Consultants
- AR 40-30, 5 Jun 51: Medical Service - Contract Surgeons
- AR 40-506, C-3, 14 Jun 51: Medical Service - Persons Eligible to Receive Medical Care at Army Medical Treatment Facilities
- SR 41-20-10, 3 May 51: Hygiene and Sanitation - Trailer Camps
- SR 40-1080-40, 8 May 51: Medical Service - Morbidity Reports, Tables and Charts (RCS MED-16, MED-73 and MED-83)
- SR 40-1080-50, 8 May 51: Medical Service - Beds and Patients Report (RCS MED-79 and MED-82)
- SR 700-51-161, 11 May 51: Supplies and Equipment - Logistic Responsibilities for Standard Commodity Classification, Major Group 61, Medical and Related Instruments, Apparatus, and Equipment
- SR 700-51-174, 11 May 51: Supplies and Equipment - Logistic Responsibilities for Standard Commodity Classification, Major Group 74, Drugs and Related Commodities
- SR 40-530-45, C-1, 17 May 51: Medical Service - Reports of Patients by Specialized Type of Treatment (RCS MED-77)
- SR 50-140-1, 21 May 51: Sanitation - Insect Control by Aircraft

- SR 40-610-20, 28 May 51: Medical Service - Social Work Services in Army Hospitals
- SR 140-105-6, C-4, 11 Jun 51: ORC - Appointment in Army Medical Service Sections
- T/O&E 8-667, C-2, 26 Apr 51: Army Medical Depot
- T/A 11-101 (8-561), 1 Mar 51: Allowances of Signal Corps, Expendable Supplies for Station Hospital, 25-Bed Communications Zone
- T/A 11-101 (8-566), 26 Mar 51: Allowances of Signal Corps, Expendable Supplies for Station Hospital, 500-Bed, Communications Zone
- ATT 8-2, 3 May 51: Training Test for Medical Battalion, Infantry Division (T/O&E 8-15N)
- ATT 8-3, 3 May 51: Training Test for Medical Collecting Company, Separate (T/O&E 8-27)
- ATT 8-4, 3 May 51: Training Test for Convalescent Center, Army (T/O&E 8-590)
- ATT 8-5, 3 May 51: Training Test for Evacuation Hospital (T/O&E 8-580)
- ATT 8-6, 3 May 51: Training Test for Mobile Army Surgical Hospital (T/O&E 8-571)
- ATT 8-7, 3 May 51: Training Test for Evacuation Hospital, Semimobile (T/O&E 8-581)
- ATT 8-8, 3 May 51: Training Test for Veterinary Evacuation Hospital (T/O&E 8-780)
- ATT 8-9, 3 May 51: Training Test for Army Medical Depot (T/O&E 8-667)
- ATT 8-10, 17 May 51: Training Test for Medical Clearing Company, Separate (T/O&E 8-28)
- ATT 8-11, 17 May 51: Training Test for Armored Medical Ambulance Company, Separate (T/O&E 8-317)
- ATT 8-13, 17 May 51: Training Test for Medical Ambulance Company, Separate (T/O&E 8-317)

PREVIEW OF THE NEW MONTHLY DENTAL REPORT

The present Report of Dental Service, WD AGO Form 8-98, will be replaced during August 1951 by Department of Defense Form 477. This form has been developed for joint use by the Army, Navy and Air Force dental services and will be available to the Far East Command about 1 September according to recent information received from the Department of the Army.

The new form is a marked departure from the current monthly report used by the Army. Due to the detail-

ed nature of the report, it will undoubtedly require revision of the tallying system generally employed in Army clinics for consolidating monthly report figures. Pending general distribution of the new form and receipt of formal instructions pertaining to its use, a brief description of DD Form 477 may be of interest to FEC dental officers.

In general the new form (Dental Service Report) is a four-page report made up of separate sheets em-

bodying a heading and five parts. The heading requires data which identifies the reporting facility and the period covered by the report.

Part I, which utilizes three of the four pages, is devoted to dental operations, treatment and diagnoses. The data required under this section are grouped under nine general headings as follows:

- | | |
|------------------|----------------------------|
| A. Restorations | F. Orthodontia |
| B. Prosthodontia | G. Miscellaneous Treatment |
| C. Oral Surgery | H. Cases |
| D. Periodontia | I. Summary |
| E. Radiodontia | |

Significant changes in this portion of the report are noted under Restorations (A) which provide for reporting one-, two-, and three-surface amalgams separately and Radiodontia (E) which likewise requires a breakdown of apical, bite-wing, occlusal, and extra-oral roentgenograms. Miscellaneous Treatments (G) include calculus removal, caries control, root canal, etc. The Summary (I) in addition to total sittings presently reported provides for separate listings of in-patient and out-patient admissions, and requires data as to the number of persons in various stages of treatment, viz., all treatment completed, essential treatment completed, treatment terminated, awaiting treatment, etc. The major change in this portion of the new report is provided by the nine (9) vertical columns as compared to "Military" and "Other" on WD AGO 8-98. The nine columns, lettered A through I, provide breakdown columns for reporting treatment, operations, and diagnosis for the following categories of personnel:

- A. Army
- B. Navy-Marine
- C. Air Force
- D. Other
- E. Total

Columns F through I, inclusive, are not captioned but preliminary information received on the subject indicates that these columns are intended for separate tabulations for certain sub-categories of individuals included in Column D - Others. The breakdown contemplated is understood to be as follows:

- F. Dependents
- G. Veterans Administration Beneficiaries
- H. Bureau of Employees Compensation Beneficiaries
- I. U. S. Public Health Service Beneficiaries (includes Merchant Seamen and officers of the U.S. Public Health Service)

Part II of the report is entitled "Examinations and Forms Completed." This section provides spaces for reporting the number of type 1, 2, 3, and 4 examinations accomplished. While no official information has been received regarding the significance of the several types listed, it is presumed that the standards enumerated in the memorandum of the Secretary of Defense on 20 October 1950 as published in the United States Armed Forces Medical Journal, Vol I, No. 12, December 1950 will pertain. The specifications for conducting dental examinations as declared at that time for the Department of Defense are as follows:

"Type 1 - Ideal Examination.--Mouth mirror and explorer examination; adequate natural or artificial illumination; full mouth intra-oral, periapical and posterior bite-wing roentgenograms; when indicated, percussion, thermal, and electrical tests, transil-

lumination, and study models."

"Type 2 - Routine Examination.--Mouth mirror and explorer examination; adequate natural or artificial illumination; posterior bite-wing roentgenograms; periapical roentgenograms, when indicated."

"Type 3 - Modified Routine Examination.--Mouth mirror and explorer examination; adequate natural or artificial illumination."

"Type 4 - Screening Examination.--Mouth mirror and explorer or tongue depressor examination; available illumination."

Part II also provides for reporting the number of various types of dental forms initiated during the month together with the number of consultations with medical officers, civilian consultants, and other specialists. Also required is a report of the number of study models for West Point candidates and others in connection with physical standards review.

Part III - Personnel, requires a comprehensive breakdown by various categories for officers, enlisted and civilian personnel as well as a "Days of Duty" analysis.

Part IV - Classification of Active Duty Personnel. Separate lines are provided for Army, Navy and Air Force Personnel. The number and percent in each of five (5) classes is required. It is presumed the change in dental classification from the present Army system (I, II, III, IV) to the Department of Defense system (1, 2, 3, 4, 5) is that embodied in the above cited memorandum of the Secretary of Defense. The designation with respect to dental classification of individuals contained in that declaration of policy is as follows:

"Class 1.--Individuals requiring no dental treatment.

"Class 2.--Individuals requiring routine but not early treatment of conditions such as:

- a. Moderate calculus.
- b. Prosthetic cases not included in Class 4.
- c. Caries -- not extensive or advanced.
- d. Periodontal diseases--not extensive or advanced.
- e. Oral conditions requiring corrective or preventive measures.

"Class 3.--Individuals requiring early treatment of conditions such as:

- a. Extensive or advanced caries.
- b. Extensive or advanced periodontal disease.
- c. Pulpal or apical infection (root canal therapy).
- d. Chronic oral infections.
- e. Heavy calculus.
- f. Cases requiring removal of one or more teeth or other surgical procedures not included in Class 5.

"Class 4.--Individuals requiring essential prosthetic appliances, including:

- a. Individuals with insufficient teeth to masticate the service ration.
- b. Other individuals in need of an appliance essential to their duty.

"Class 5.--Individuals requiring emergency dental treatment for conditions such as:

- a. Injuries.
- b. Acute oral infections (parietal and periapical abscesses, Vincent's infection, acute gingivitis, acute stomatitis, etc.)

c. Painful conditions."

Part V of the form is the Remarks Section where it is understood will be listed all organizations and activities of other commands and services receiving dental care at the hands of the reporting facility, equipment data, buildings occupied, etc.

REGISTER OF DENTAL PATIENTS

Attention of dental officers is invited to Change 6, AR 40-100, dated 22 June 1951, which prescribes a new procedure for the retirement of register cards, WD AGO Form 8-116. Under the revised system, the permanent file will be maintained on a bimonthly basis, cut off on the last day of each even-numbered

month and a new file established on the first day of an odd-numbered month. After 1 July 1951 such records will be held for six months and then retired as indicated in the above cited change to AR 40-1010. Disposition instructions are also given for permanent files for the year 1950 and for the 6-month period, January to June 1951.

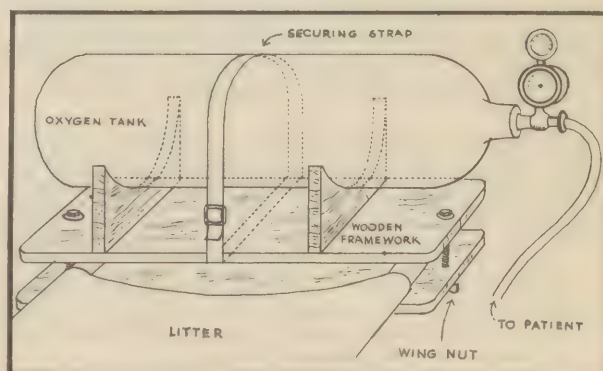
OXYGEN UNIT ADAPTED FOR LITTER USE

An oxygen apparatus so arranged to insure the uninterrupted flow of the life-saving gas to patients being evacuated has long been in demand.

Cpl. Earl Barber, 22d Hospital Train Detachment, tackled the problem and came up with a solution that has proved highly effective during the operation of his unit.

Cpl. Barber strapped an oxygen tank to a wooden framework that is quickly attached to any type of litter. The tightening of two wing nuts clamps the framework to the litter handles at the head of the patient. Its position of accessibility makes the apparatus easily operated by assistant ambulance drivers, medical technicians or nurses aboard ambulances, trains or planes.

The unit may be removed from the litter in a matter



of seconds and placed in position for routine bedside use.



THE HOSPITAL COMMAND TEAM

Lt Colonel Floyd C. Plowman, MSC, 3d Station Hospital, APO 59

The combined problems of hospital and post management make the administration of large fixed Army hospitals difficult and complex.

The accounting for and expenditure of millions of dollars; feeding, clothing, housing and record-keeping of thousands of personnel; construction, repair and utilities for a small city

and the proper functioning of professional services are but a part of the task.

It is not enough to place wise and experienced hospital administrators in charge of these hospitals; a sound, practical organizational chart must be given them to work in. At the top of this chart is the command block. The Commanding Officer, Deputy Commanding

Officer and Executive Officer form the command "Team". Although the responsibility for the proper functioning of the hospital is placed solely on the Commanding Officer, the work is divided among all three members of the team.

Time calls for change. There is a constant need to study Army hospital organization to keep it up-to-date.

An era in Army hospital administration ended in October 1940 with the rapid expansion of the Army. Many of our medical officers had never commanded any hospital; others had commanded hospitals of less than 100-bed capacity. These officers were now needed to command large hospitals of 500 beds or more.

We entered this period with a very small hard "core" of trained non-commissioned officers and a small number of potential non-commissioned officers. Many of these were later commissioned and cadres for new units further reduced our NCO stock. Our regular Army Med-

ical Administrative Corps had fewer officers in it than are now stationed on some posts. Our reserve officer rosters were short. With these problems to face, it was impractical at that time to institute Army-wide hospital reorganizational changes.

From Pearl Harbor to V-J day money was plentiful and supplies were sufficient despite war demands. Selective service assured a continuous flow of personnel. Economy was placed secondary to the problem of winning the war. However, after V-J day the situation changed. We had large pools of trained officers and noncommissioned officers. The personnel situation was more stable. Funds were becoming harder to get, supplies and equipment needed to be conserved and personnel ceilings were being readied for the ax. The time had come to reorganize hospitals for the maximum of efficiency and economy. The place to start was in the command block.

Further factors called for change. A casual review of several hospital organizational charts showed little semblance of a standard organization. Physical layout, type of patients treated, and activities staffed by Army commanders all showed marked differences. In order to develop a suitable cost accounting system a standard organization was needed. The Bureau of the Budget was having difficulty comparing costs among hospitals. The hour was late and Army hospital administration was behind the times.

To correct this condition a modern hospital reorganization program was begun by The Surgeon General. The plan was firmed up at Valley Forge Army Hospital in 1949 and early in 1950 the rest of the Army hospitals in the ZI were scheduled for the change-over.

The duties of the Commanding Officer have been changed but little under the reorganization plan. His duties however have been made easier thereby. He is a Colonel or General of the Medical Corps.

The position of Deputy Commanding Officer was created in order to give the Commanding Officer a full time assistant in hospitals having more than a thousand beds. It is intended that he oversee the administrative activities of the various professional services. In this way the Commanding Officer is able to spend more time on major planning and on overall coordination and control. The position also serves as a training and developing ground for future hospital commanders. This officer initiates action leading to the appointment of boards of medical officers and supervises their activities; reviews the reports of such boards and advises the Commanding Officer thereon.

The supervision of the professional training program is also the responsibility of the Deputy Commanding Officer. By closely watching patient length-of-stay he may assert a strong influence in keeping patient days at a normal level. His other duties include representing the Commanding Officer in relations with civil health authorities, coordinating the Civilian Consultant Program, advising the Chief of Supply Division on the procurement of nonstandard medical supplies, supervising the operation of the medical library and if so directed, he may act as the Medical Inspector. The Deputy Commander is a senior field grade officer of the Medical Corps.

The duties of the Executive Officer have been enlarged. Instead of using such broad terms as "coordinates" and "assists" as used in former directives, an effort has been made to "spell out" his duties and

responsibilities in more detail. He is charged with the supervision and leadership of the administrative services. Ideally, following the doctrine of completed staff work, he makes routine administrative decisions and takes routine administrative action without reference to the Commanding Officer or Deputy Commanding Officer. Nothing herein should be inferred, for nothing is implied, that the Commanding Officer should not be kept well-informed. The Hospital Commander can function efficiently only when he is fully aware of what is going on in his unit. In awareness of the "team" concept, the wise Executive Officer soon learns those things he should do independently, those things he should do in conjunction with the Deputy Commander and finally those things that should require the interconsultation of all three.

In conjunction with the Management Officer the Executive Officer develops and institutes standard practice procedures to be followed in the initiation and processing of administrative actions. Other duties include the review of proposed hospital regulations and other local administrative directives, the initiation of action leading to the appointment of investigating officers and other administrative boards and review of completed boards and finally, advising the Commanding Officer thereon.

The Adjutant was removed from the command block and placed in the personnel division. This change is another subject. It is only mentioned to explain why the Executive Officer, or his Administrative Assistant, authenticates official publications other than special and letter orders. Finally, the Executive Officer or his assistant acts as office of signature on correspondence for, and in the name of the Commanding Officer.

The Administrative Assistant, a company grade MSC officer, assists the command team. He serves as Postal Officer, Security Officer for classified material, Billetting Officer, Records Administration Officer and Office Manager for the office of the Commanding Officer. His office is subdivided into a Mail and Records unit, a Publication unit and a Postal unit. He also supervises the Hospital Information office. Although he serves the entire command team he is directly responsible to the Executive Officer for the proper performance of his duties. It is not intended or desirable that this officer issue any verbal or written orders in the name of the Commanding Officer. He performs an office service; his contacts with other hospital personnel are purely of an administrative nature.

The Command Team is assisted by a special staff composed of the Hospital Inspector General, Public Information Officer, Judge Advocate and Hospital Chaplain. The duties of this special staff are unchanged. The Hospital Chaplain also serves as Chief of the Chaplains Branch Welfare Division.

This headquarters organization was set up in December 1949 and continued until July 1950 when Valley Forge Army Hospital was closed. It has been placed in operation in our largest fixed hospitals. This organization proved sound, efficient and flexible. The office of Deputy Commander was a valuable training ground for a future Commanding Officer. It also gave the Hospital Commander a valuable full-time assistant. The placing of a Medical Service Corps officer as the

head of the Administrative Services in large Army hospitals was proved practicable. New horizons of responsibility were opened to the Medical Service Corps. The Adjutant was placed under the Chief of Personnel, another move that proved sound.

It was felt the "top" had to be overhauled before the many changes needed in the lower hospital structure could be made. The steadily increasing efficiency of the unit combined with a continuous gain in economy proved this reasoning was correct.



CHINESE WOUNDED GIVEN SAME MEDICAL CARE AS UN PERSONNEL

Thousands of Red China's soldiers, ripped by American heavy artillery and left behind as their comrades fled northward under a rain of gunfire, are being given life-saving first aid in UN medical installations immediately after capture.

Severely wounded Reds are rushed to aid stations and hospitals with the same speedy facilities accorded

UN soldiers, according to Lt. Colonel Hubert L. Binkley, X Corps Surgeon. At hospitals they are placed in the same operating rooms as the injured GI's and until they are able to be moved to prisoner of war camps far to the South, they lie on cots in the same tents with the men they tried to kill only hours earlier.

Told by their Communist leaders that the UN Forces murder all prisoners, they find the treatment impossible to believe.

"Most of them are happy to get out of the war," according to one American officer. "No matter what the extent of their injuries, they're glad it's all over for them." They believe there is some catch to the treatment they receive, especially when they are given a rice diet instead of the corn meal they have been eating for weeks.

One frontline hospital, during the rise and fall of the recent Red offensive, administered aid to 153 badly wounded prisoners who had been brought in from the battlefield. Nearly all of the, their bodies gashed by artillery fire, had maggots crawling within their wounds. "It saved their lives," Major Edmund D. Bennett of the 8225th Mobile Army Surgical Hospital staff, said. "It was a horrible sight, but the maggots helped keep the wounds clean."

Red China, although it has never ratified the Geneva Convention, is apparently subscribing to the rules of warfare in regard to the sick and wounded, according to Colonel Binkley. "While they do not have the best of medical supplies, information indicates that they are giving our wounded equal treatment with their own, to the best of their ability,"

TECHNICAL

Backache	131
Immunization Requirements of the Far East Command.	133
Arterial Transfusion in a Mobile Army Surgical Hospital.	139
Orientation to Psychiatric Problems in the Far East Command.	141
Cnanchroid	142
Notes on Dental Materials.	145
Branchial Cleft Cyst - A Case Report	146

BACKACHE
Capt Philip R. Dodge* MC, USA; Col Edward A. Cleve, MC, USA, Tokyo Army Hospital

INTRODUCTION:

To our lay society and fighting men, the enigma of the "poor aching back" is well-known, and the physician's dilemma, in this regard, is equally well-recognized by patient and doctor alike

In the Far East Command, backache presents a maj-

or problem faced daily by physicians in nearly every medical specialty at all levels of medical care.

At the Tokyo Army Hospital, large numbers of patients examined presented the chief complaint of backache with and without associated leg pains. The

* Formerly assigned to the Tokyo Army Hospital.
Present address: Neurological Unit, Boston City Hospital, Boston, Mass



majority of these patients came from military units and organizations actively engaged in combat, or from installations directly in support of tactical units. Almost without exception they were referred here with the diagnoses of some type of organic disease, and yet it became increasingly apparent, in a large percentage of these cases, that objective evidence of significant organic disease was sorely lacking. It seemed worthwhile therefore to report our experiences with a considerable number of patients with backache in the hope of clarifying some of the problems of diagnosis and management.

PRESENT STUDY:

The clinical records of 122 patients seen in this hospital in a five month period, from November 1950 through March 1951, were reviewed. These patients were studied on the Medical Service and represent the consecutive cases observed during the above period by seven medical officers¹ in addition to the authors. During this period patients suspected of having a herniated nucleus pulposus, lumbosacral strain, myofascial syndrome, sacro-iliac joint strain, sciatica, arthritis, and congenital abnormalities were admitted to the Medical Service. Many of these patients would have been referred directly to various other specialties such as Neurosurgery and Orthopedics, but because of the heavy patient load carried by those services and an interest in backache on the part of the Medical Service, they were studied and treated by the internists. This afforded a unique opportunity for seeing a wider spectrum of disease than would ordinarily be encountered on a general medical service.

In the group of patients thought to have no organic disease, specific psychiatric diagnoses were not always made. For the purposes of the tabulation they have been classified as "No Organic Disease Found". This group of cases was sub-divided, however, into two groups: (1) Those with a history of acute trauma or strain immediately preceding symptoms and (2) those with no history of acute trauma or strain immediately preceding symptoms.

METHOD OF EXAMINATION:

The diagnosis was made in each case by a careful history, physical examination, and a minimum of laboratory study. Each history included a detailed analysis of the chief complaint and associated symptoms. Special attention was paid to the onset and duration of the illness. The influence of various physical and emotional factors and the appearance and severity of symptoms was noted. An attempt was made to ascertain how strong was the patient's motivation for recovery. A detailed review of systems was employed. Family and social histories were recorded.

Physical examination included specific tests designed to determine the functional integrity of the spine and associated structures. The general contour of the low back, including the degree of lumbar lordosis and/or scoliosis was noted. The patient was instructed to bend over and touch his toes with knees stiff. He was asked to flex laterally, forward flex, and extend his spine. Hip joints were flexed, extended,

and rotated. Stress was applied to the sacro-iliac joints. Straight leg raising was performed with the patient lying and sitting. The sciatic notch region was palpated. A rectal examination was done. Neurological examination included the testing of gait, motor power, reflexes, and sensation. The usual blood and urine examinations as well as a blood sedimentation rate were done on each patient. X-rays were taken of the involved parts and a lumbar puncture secured when specifically indicated by the presence of neurological symptoms or signs.

RESULTS:

Organic Disease:

The diagnoses were tabulated in table #1. Definite evidence of organic disease was found in 47 patients, or 38.5%. Some of these patients gave histories and displayed findings suggesting the presence of an associated neurotic illness. These people were classified as having organic disease even though such a neurotic factor, which may well have been responsible for the severity of symptoms or disability produced by the illness, was present. Patients with backache and certain congenital abnormalities such as spina bifida occulta and sacralization of the 5th lumbar vertebra but excluding spondylolisthesis were considered to have no organic disease. These conditions exist so commonly in asymptomatic individuals that serious doubt is cast on their ability to produce symptoms. Moreover, most of these patients presented some positive evidence of a neurotic illness.

Each of the following organic diseases, presenting with the chief complaint of backache was encountered once: juvenile epiphysitis, traumatic arthritis, structural scoliosis (secondary to an old shortening of one leg), acute seminal vesiculitis, poliomyelitis, and an acute pilonidal sinus infection. Two cases of compression fracture and six cases of typical rheumatoid spondylitis were seen. The criteria for diagnosing these conditions are well known and will not be defined here. In most instances their diagnoses presented no problem, and they were treated in the generally accepted manner. Except for the cases of pilonidal sinus infection and acute seminal vesiculitis who were returned to full duty on recovery, all cases with organic disease were evacuated to the ZI for further care and final disposition.

Ten patients were diagnosed as having their symptoms secondary to acute trauma or musculoskeletal strain of the low back. This diagnostic category was set up to include those patients who, for the most part, were stable, well-motivated and non-neurotic individuals. They gave a well-documented and clear-cut history of significant trauma, associated with local bruising, tenderness, splinting of the back, and had no specific neurological or roentgenographic abnormalities. On conservative management, with bed rest and physiotherapy, they recovered and lost their symptoms in a matter of a few days to a few weeks. In general the pattern of their symptoms and signs coincided well with the pathology of an acute musculoskeletal bruise or strain. All cases were returned to duty, and accepted their disposition, without serious objections.

The greatest confusion in differential diagnosis arose in relation to the syndrome of the herniated nucleus pulposus. Twenty-three patients, or 18.9% of the 122 patients, were seen with a typical his-

¹Capt James W. Mankin, MC; Capt Richard E. Weeks, MC; Capt Robert C. Bolin, MC; Lt (jg) Garth K. Graham, USNR, MC; Capt George W. Pogson, MC; Lt Col Charles J. Hornisher, MC; Capt Herhsall J. Wells, MC.

Immunization Requirements of the Far East Command

References

Section III, Army Regulations 40-210

Army Regulations 40-215

Army Regulations 42-40

Navy Department General Order No. 20

Air Force Regulations No. 160-26

GHQ, FEC Circular No. 9, 27 February 1950

TB MED 114, War Department

CINCFE Msg ZX 34930, 22 January 1951

CINCFE Msg ZX 40004, 20 February 1951

A Guide to Worldwide Immunization Requirements, issued by
The Air Surgeon, Military Air Transport Service, 15 January 1951
and changes thereto

		SMALLPOX	TYPHOID-PARATYPHOID	TETANUS	CHOLERA	TYPHUS
JAPAN	Departure for	Within 6 Months	Basic Series or Stimulating Dose within 6 Months	Basic Series within 1 Year or Stimulating Dose within 4 Years	Basic Series or Stimulating Dose within 6 Months	Basic Series or Stimulating Dose within 6 Months
	Duty in	Annually	Stimulating Dose Annually	Stimulating Dose within 1 Year after Basic Series; Every 4 Years after last Stimulating Dose and upon Occurrence of Wounds or Burns	Not Required	Stimulating Dose Annually
KOREA*	Departure for	Within 6 Months	Basic Series or Stimulating Dose within 6 Months	Same as Japan	Basic Series or Stimulating Dose within 6 Months	Basic Series or Stimulating Dose within 6 Months
	Duty in	Every 6 Months*	Stimulating Dose Annually	Same as Japan	Stimulating Dose as directed by CG, EUSAK	Stimulating Dose as Directed by CG, EUSAK
RYUKYUS COMMAND	Departure for	Within 1 Year	Within 1 Year	Same as Japan	Basic Series or Stimulating Dose within 1 Year	Not Required
	Duty in	Every 3 Years	Stimulating Dose Annually	Same as Japan	Not Required	Not Required
MARIANAS RONINS COMMAND	Departure for	Within 1 Year	Within 1 Year	Same as Japan	Not Required	Not Required
	Duty in	Every 3 Years	Stimulating Dose Annually	Same as Japan	Not Required	Not Required
PHILCOM (AF)	Departure for	Within 1 Year	Basic Series or Stimulating Dose within 1 year	Same as Japan	Basic Series or Stimulating Dose within 1 Year	Not Required
	Duty in	Every 3 Years	Stimulating Dose Annually	Same as Japan	Not Required	Not Required

*

Korea is an epidemic Smallpox area, hence personnel departing from Korea, regardless of destination, must have been successfully vaccinated against Smallpox not less than two (2) weeks prior to departure and within the previous six (6) month period. An exception to this rule may be made for emergency medical evacuees.

Notes

DIPHTHERIA: Diphtheria immunization or a Schick negative status is required for all dependents in the FEC between the ages of six (6) months and fifteen (15) years. Stimulating doses of diphtheria toxoid should be given two (2) and five (5) years after initial series. (When given in combination with pertussis vaccine, diphtheria toxoid may be administered to infants three (3) months of age.

JAPANESE B ENCEPHALITIS and INFLUENZA: Japanese B Encephalitis and Influenza vaccinations are special procedures applied as directed by the Commander in Chief, FEC, and their accomplishment is not a requirement for travel. For the 1951 season, Japanese B Encephalitis vaccination is required in Japan, Korea and Okinawa.

TRAVEL TO JAPAN FROM KOREA: Compliance with requirements for duty in Korea fulfills the requirements for travel to Japan from Korea except with respect to smallpox vaccination as indicated in footnote on preceding page.

TRAVEL to the UNITED STATES, HAWAII and ALASKA: Compliance with requirements for duty in the area being departed fulfills the requirement for return to the United States, Hawaii and Alaska except with respect to Smallpox vaccination for those departing from Korea as indicated in footnote on preceding page

REQUIREMENTS for OTHER TRAVEL: Requirements for travel to areas outside the FEC and other than directly to the United States, Hawaii and Alaska vary considerably and depend in large part on the requirements of the countries of transit and destination. For these requirements reference should be made to TB MED 114 (for strictly military requirements) and to MATS "Guide to Worldwide Immunization Requirements", dated 15 January 1951, for overall and local requirements. For information concerning special cases and situations, queries should be made to the major command surgeon or to the Medical Section, GHQ, FEC.

tory and findings of a herniated nucleus pulposus. Each individual in this group had at least one of the following signs in addition to a classical history of root irritation: (1) Localized muscular weakness. Weakness of the glutei and long extensor of the great toe was most commonly seen, (2) diminution or loss of a tendon reflex, (3) sensory changes consistent with a dermatome distribution, and (4) elevation of the cerebral spinal fluid protein. Reliance on these signs was found necessary. Frequently patients in whom no organic disease was found -- more specifically, cases of hysteria without the objective paralytic and anesthetic stigmata -- presented rather convincing histories of root irritation. The explanation for this similarity in the histories was felt to be iatrogenic in most instances. That is to say, suggestible individuals who had been questioned many times on specific diagnostic features of their illness by several physicians in the chain of evacuation subsequently incorporated these points in their own stories. For example, they would be asked, "Do you have shooting pains in your legs?" or, "Does your pain have any relation to coughing, sneezing, or straining at stool?". Evidence tending to support the view that additional symptoms were frequently grafted upon the basic complaints in suggestible individuals was found when negative statements in previous histories regarding their symptoms were compared with the later positive statements in which such symptoms were said to have preceded in time the earlier recorded histories. Frequently these subjective features were volunteered in a stereotyped fashion suggesting that they have been acquired by rote. Some patients with typical textbook complaints gave the history of past association with patients having a root irritation syndrome. The importance of this source for symptoms is more speculative, but tended to raise in us a high index of suspicion. Evidence tending to support the contention that such subjective complaints are unreliable is seen in discouraging results recorded in the literature of many competent neurosurgeons who, in the past, have frequently found no herniated nucleus pulposus when explorations were performed on Army patients with subjective disc symptoms alone. In such cases, the patient's symptomatology was not significantly altered, and he was provided with indisputable evidence of organic disease.

Ancillary signs used in the diagnosis of a herniated nucleus pulposus such as flattening of the lumbar lordosis, scoliosis, limited straight leg raising, increased radicular pain on jugular compressions, tenderness over the sciatic nerve and narrowing of the appropriate vertebral interspace were at times helpful but less reliable than the four listed above. If a constellation of these were present in a stable, non-neurotic individual who presented a good history, although without objective signs of root compression, the diagnosis of herniated nucleus pulposus was strongly suspected. He was then treated for a few weeks on bed rest, bedboards and flexion exercises. If he responded with marked improvement on this regime, then the probability of organic disease -- more specifically, herniated nucleus pulposus -- was strengthened. Several patients in this group were returned to duty. For the purpose of tabulation in this report they were included under the heading of "Etiology Not Determined". Because of the iatrogenic implications care was taken to withhold the possible diagnosis of herniated nucleus pulposus from the patient.

Management of the group with good objective evidence of a herniated nucleus pulposus was also conservative. If the objective findings persisted the patient was evacuated to the United States for more prolonged observation, evaluation, treatment and possible neurosurgical intervention. A few of these patients made startling and complete symptomatic recoveries, lost their objective signs and were returned to duty. Such patients accepted this duty disposition without complaint in contra-distinction to a high percentage of those in the non-organic group who denounced their physicians privately and publicly for such an injustice.

No Organic Disease Found:

No compelling evidence of organic disease was found in 66 of the 122 patients, or 54.2%. Thirty, or 24.6% of the total group, reported trauma or strain prior to the development of their complaints. This varied from such insignificant precipitating factors as lifting a nine pound rifle or being struck in the back by a small stone, to trauma of such magnitude as being thrown "fifty feet" by a blast or being pinned beneath a three-quarter ton truck. Some patients immediately became "paralyzed all over", "numb from the neck down", "blind", or developed other hysterical symptoms associated with "mashing", or "tearing pains" in the back. Others merely developed back pain. Often the patient gave a history of freedom from symptoms for the immediate post-traumatic period only to develop the severe back pains hours, days, or even weeks later. Some patients were evacuated immediately while others made repeated sick call visits before convincing the medical officer of their need for hospitalization. Despite the often dramatic nature of the histories we were impressed by the paucity of valid objective signs here or at any point in the medical evacuation. The incongruous nature of the neurological findings in hysteria as compared to subjective complaints offered little diagnostic difficulty. A "touch-me-not" attitude was common when the back was examined. More specifically, a superficial or light touch over the back in any area would elicit marked withdrawal and painful grimaces. With patience and reassurance a more thorough examination was possible. None showed any external evidence of trauma, such as ecchymosis or abrasion that would be expected from the history. Muscular spasm of paravertebral muscles was occasionally found. Rarely was scoliosis seen. More often than not the patient could perform all back maneuvers without restriction, although encouragement and reassurance were frequently necessary. Straight leg raising with the patient in the supine position was sometimes thwarted by hamstring spasms, and attended by marked grimacing and perspiring. However, with the patient in the sitting position extension of the leg to ninety degrees could be accomplished with ease although this maneuver places similar stress on the sciatic nerve. Neurological examinations and laboratory studies including spine x-rays were negative.

Characteristically, this group did not improve on bed rest and physiotherapy, but clung tenaciously to its complaints. Striking anxiety symptoms were commonly seen and often appeared to increase rather than decrease during the hospital stay. At the onset, no doubt, many of these patients had probably sustained significant trauma with resulting physical injury, but the functional incapacity, severity, and persistent nature of symptoms were far out of proportion to any organic disease. When one delved into their past and present personal histories, there was usually evidence of poor motivation with multitude of com-

plaints such as dizziness, fainting spells, blackouts, anxiety symptoms, paralyses, paresthesias and headaches.

The group without organic disease and with no history of acute trauma anteceding the development of the present episode, often have a history of recurrent backache. Thirty-six patients, or 29.6% of the 122 patients fell into this group. Almost without exception these patients gave a history of long continuous suffering from low back complaints with frequent severe exacerbations seemingly timed with periods of emotional stress, disagreeable duty, or undesired assignment. They were "never free of low backache" which had often been with them for years. It is interesting that many insisted they had less pain when in a specific "climate", usually found near their home in the ZI. There was usually less overt anxiety apparent in this group. They frequently reported the details of multiple previous hospitalizations which were often of several weeks or months duration. Their histories were replete with such diagnostic terms as "ruptured disc", "pressure on the nerves", "sciatic rheumatism", or some form of congenital abnormality. Some had myelograms and a few an "exploratory operation."

Seldom did they report that they had been told no organic disease was found. Such fixed symptomatology invites the unwary examiner to consider seriously the diagnosis of a herniated nucleus pulposus. However, the validity of these statements was open to question and in some instances were certainly the result of misinterpretations and even untruths.

It is pertinent to mention at this point that not infrequently one or more physicians had the distinct impression that a patient was deliberately manufacturing his illness in a calculated manner, i.e., malingering. Such an impression was often hard to escape, especially when the obvious gains for the patient brought about by his illness are so great. This diagnosis was not made in this series of patients for undeniable proof of malingering was difficult to obtain.

Once the diagnostic studies were complete, individuals felt to have "No Organic Disease" were told the result of their examination. Detailed explanations of the origin of their pains were avoided. They were usually informed that psychological mechanisms, not structural disease, were the basis of their symptoms. The fact that they had pain was not denied, but it was insisted that they must live with the symptoms and return to duty since no medical disability existed. An attempt was made to be firm but understanding. Although some patients accepted this fairly well, the prevailing attitude of most patients in the non-organic group was one of a refusal to accept the diagnosis, and unavoidable disposition. At this point, statements such as: "I don't understand it"; "There must be some cause of this pain"; "That's what all the doctors say"; or, "Pains are not in my head", were common. Many became quite aggressive and demanded that "something be done". On several occasions the physicians in charge felt that they were in real danger of physical assault, so marked were the hostile reactions. A few made formal complaints to the Inspector General.

All braces, canes, and similar appliances were denied the patients with no organic disease, except

that occasionally a patient with an acute hysterical paralysis of the legs was allowed to use crutches for a day or so in order to make his recovery appear to progress at a reasonable rate and thereby save face for himself in the eyes of his ward mates.

The total final dispositions made in the non-organic group are recorded in table #2. Approximately 70% were returned to full duty, 20% to non-combatant duty, and 10% with the more severe neurotic symptoms were transferred to a psychiatric hospital for further treatment. How many will be re-evacuated to other hospitals is unknown, but to date less than half dozen have returned to this hospital after a 3 - 8 month period. There is no doubt that some will find their way back at a future date.

Patients of special interest, found in the non-organic group were individuals having a chronic tension state. Almost invariably, such persons were NCO officers who had excellent work records because of a compulsive and perfectionistic personality. Their presenting symptomatology was a chronic, annoying low backache, usually associated with muscular aching between the shoulder blades and at the base of the skull. This was accompanied by typical tension headaches. The muscles were tense and sore on examination and the symptoms responded exceptionally well to simple muscle relaxing devices such as massage and hot showers. This patient readily recognized the association of backache with the other anxiety symptoms and was quite willing to accept the emotional origin of this discomfort. He was relieved to learn that there was no serious illness and with this reassurance accepted a duty disposition considerably better than most others in the non-organic group.

In this study the clinical characteristics of the various disease entities which produced backache have been presented. Special emphasis has been placed on the differential diagnosis between the group of patients with and without organic disease. The problems of management and disposition have been discussed.

SUMMARY:

Backache has been a common medical complaint in the Far East Command during the Korean campaign. One hundred and twenty-two patients with the chief complaint of backache were seen on the medical service at the Tokyo Army Hospital during a five months period. Only 38.5% were found to have good objective evidence of organic disease.

The article "Backache" is one of many articles which will appear in the forthcoming "Symposium of Military Medicine in the Far East Command", now in preparation by the Medical Section, GHQ. The Symposium will be a supplementary issue of the SURGEON'S CIRCULAR LETTER.

TABLE I

CLINICAL DIAGNOSES OF 122 PATIENTS PRESENTING ON THE GENERAL MEDICAL SERVICE WITH THE
CHIEF COMPLAINT OF BACKACHE

<u>ORGANIC DISEASE</u>	<u>Number</u>	<u>Percentage</u>
Herniated nucleus pulposus.	23	18.9
Acute trauma or low back strain.	10	8.1
Rheumatoid spondylitis.	6	5.0
Compression fracture.	2	1.7
Juvenile epiphysitis.	1	.8
Traumatic arthritis.	1	.8
Structural scoliosis.	1	.8
Acute seminal vesiculitis.	1	.8
Poliomyelitis.	1	.8
Pilonidal sinus infection, acute.	1	.8
TOTALS	47	38.5
<u>NO ORGANIC DISEASE FOUND</u>		
History of trauma or strain immediately preceding symptoms.	30	24.6
No history of trauma or strain immediately preceding symptoms.	36	29.6
TOTALS	66	54.2
<u>ETIOLOGY NOT DETERMINED</u>	9	7.3
TOTAL	122	100.0

TABLE II

DISPOSITION OF 122 CASES OF BACKACHE SEEN ON THE MEDICAL SERVICE*

<u>ORGANIC DISEASE</u>			<u>NO ORGANIC DISEASE FOUND</u>			
	<u>Number</u>	<u>Percentage</u>	<u>History of trauma or strain immediately preceding symptoms</u>		<u>No history of trauma or strain immediately preceding symptoms</u>	
			<u>Number</u>	<u>Percentage</u>	<u>Number</u>	<u>Percentage</u>
Full Duty	14	29.8	20	66.7	25	69.4
Zone of Interior	26	55.3	0	0	0	0
Limited Duty	3	6.4	3	10.0	4	11.1
Psychiatric Center	0	0	7	23.3	6	16.7
No information	4	8.5	0	0	1	2.8
TOTALS	47	100.0	30	100.0	36	100.0

(*Excluding 9 patients on whom no definite diagnosis was made.)

ARTERIAL TRANSFUSION IN A MOBILE ARMY SURGICAL HOSPITAL

Howard P. Sawyer, Captain, MC, 8063rd Mobile Army Surgical Hospital

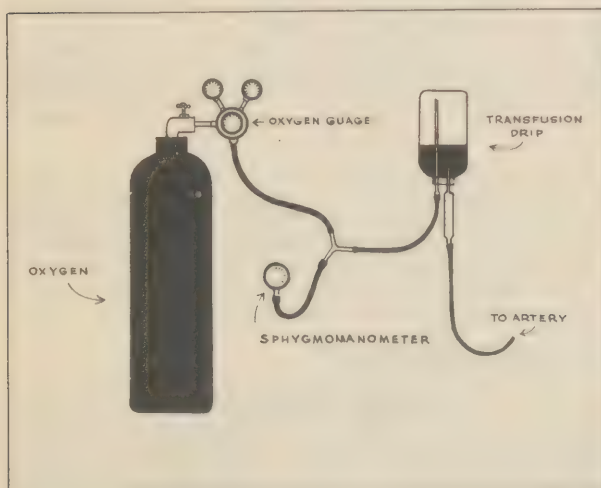
Due to the number of patients suffering irreversible shock despite whole blood replacement, an attempt has been made to find a method of more rapidly restoring circulatory volume that would be practicable in a mobile surgical hospital. Occasionally in patients whose wounds involve a large blood vessel the blood loss is such that the more simple procedures are inadequate, i.e., using the external jugular vein, which incidentally can frequently be entered when no peripheral veins are apparent, or using a short length of rubber infusion tubing with a blood pressure bulb to pump air into the blood bottle.

The circulatory volume can be more readily restored and with a smaller amount of blood by using the arterial rather than the venous route. A readily available point of entry is the radial artery at the wrist, whenever possible, using the opposite of the dominant hand because of the small but ever present possibility of gangrene.

MATERIAL:

The equipment consists of a tank of oxygen, a reducing-regulating gauge, rubber tubing, heavy silk thread, a glass Y adapter, an aneroid sphygmomanometer,

a recipient transfusion set, a 15 or 17 gauge needle, an 18 gauge cannula and a 4 inch 22 gauge needle. Roughly two or three feet of rubber tubing, whatever size is available and fits, connect the oxygen gauge to the Y adapter. One limb of the adapter is connected by a foot of rubber tubing to the sphygmomanometer. The other limb is connected with infusion tubing to a 15 or 17 gauge needle, which is in turn inserted into the air vent of the blood bottle. All connections should be reinforced with silk ties, and as an added precaution the rubber stopper in the bottom of the transfusion drip should be taped to the glass wall. The needles and cannula are kept sterile in a pack, and the necessary thread, Y adapter and tubing kept together for immediate availability. The only other necessary equipment is a "cut down set", which may be kept in a sterile pack or assembled when needed in the operating room.



If a reducing-regulating gauge is not available, a somewhat less satisfactory but usable substitute is an anesthesia machine provided it has no bad leaks. The breathing tubes are disconnected and the inhalation pipe attached by means of two endotracheal adapters to a length of rubber tubing and hence to the glass Y adapter. When in use it will be necessary to compress the collapsed rebreathing bag against its connection in order to prevent overdistension of the bag.

TECHNIQUE:

The services of two persons are required, one of whom if necessary, may be administering anesthesia. With the hand stabilized in full supination and dorsiflexion a three quarter inch longitudinal incision is made over the distal end of the radius where the radial artery is palpable. The artery is identified, freed up, and two lengths of no. 00 silk suture passed underneath as one would do for a venous cutdown.

The vasospasm resulting from shock and trauma to the artery may be so strong as to prevent the transfusion of blood even under considerable pressure. It is countered first by laying a sponge soaked in 1% procaine over the incision for 30 seconds or squeezing a few drops into the incision. Then procaine is injected with a 4 inch 22 gauge needle

around the radial artery for several inches proximal to the incision. Next a V shaped incision with the vertex proximal is made in the artery preferably with a fine pair of scissors and the cannula inserted. Rather than tying the cannula in place, the ends of the ligature are crossed over the artery and cannula and held with a clamp. While this is being done, someone else should slowly increase the pressure into the blood bottle, (previously warmed to room temperature), so the system is free of bubbles and the blood extends to the end of the recipient set tubing which is then connected with the cannula. The junction is then covered with gauze and stabilized with tape.

The pressure to be applied can be regulated according to the rate of blood flow as visualized or by the pressure on the sphygmomanometer. Rarely is it necessary to exceed a pressure of 275 mm of mercury and generally 120 mm will suffice. The rate of flow and amount of blood transfused are judged by the patient's response. Frequently a definite improvement is noted after as few as 300 cc's have been infused and on occasion 7,000 cc's were required before a nearly normal hemodynamic status was restored.

When changing blood bottles the pressure should be completely and rapidly reduced and a clamp applied to both the inlet and outlet tubing well below the bottle. The bottle is then changed, the pressure slowly increased and the clamp released. If at any time an immediate drop in pressure is required, the sphygmomanometer can be briefly disconnected.

When the desired hemodynamic status has been maintained for a reasonable period, adequate hemostasis secured and a venoclysis started the arterial transfusion is terminated. Even in the presence of complete recovery from shock the transfusion should never be withdrawn until adequate hemostasis has been secured.

In terminating the transfusion the oxygen is shut off, the clamp released from the ligature and transferred to the infusion tubing, the cannula withdrawn and firm pressure applied. If after five minutes of pressure the artery still bleeds, it should be ligated above and below the incision and the skin closed. Otherwise the silk ligatures are removed, the skin closed, and a pressure dressing applied in such a manner as to create pressure locally but not interfere with the collateral circulation.

Very rarely gangrene of the lateral aspect of the hand may result so every effort should be made to prevent this. Some advise wrapping the hand in cotton batting to retain body heat, but it would seem more logical to keep the hand at room temperature rather than increasing the metabolism before adequate collateral circulation has developed. The stellate ganglion should be blocked with one percent procaine after the transfusion is completed. The circulation of the hand should be very closely followed for several days and the stellate ganglion blocked as often as indicated, which for the first day may be as often as every eight hours.

In addition because of its vasoconstrictive action morphine should be avoided as a post-operative analgesic, demerol being preferred.



ORIENTATION TO PSYCHIATRIC PROBLEMS IN THE FAR EAST COMMAND
Colonel Albert J. Glass, MC, Psychiatric Consultant, GHQ, FEC

It is the purpose of this article to assist in the orientation of medical officers, newly arrived in this command, with special reference to the psychiatric problems in the FEC. It is known that very few of these officers have had psychiatric training or are interested in pursuing a career in this specialty. However, they

are aware that in civilian medicine the psychological components and manifestations of organic disease are quite prevalent. It should not come as a surprise to learn that a wartime situation, with its unavoidable deprivations and vicissitudes, would serve to increase the psychic elements in disease to such an extent that it must be considered as a factor in most of the patients that medical officers will encounter. In addition, there are the overt psychiatric casualties produced by dislocation from their families and the terrorizing effect of combat.

In the transition from civilian to military medicine, perhaps the most difficult professional obstacle to be overcome is a reorientation of the physician's attitude toward the patient. In civilian life, the patient is in a position of pre-eminent importance. He expects the doctor to consider only his needs and desires. By contrast, the medical officer is concerned primarily with the welfare of the group. His principal goal is to maintain the effective strength of the military unit. This attitudinal difference between civilian and military practice does not concern actual treatment procedures. Here the military objective demands a high degree of professional skill in order to restore the individual to the strenuous activity required on a duty status. It is primarily when the medical officer is confronted with questions of diagnosis and disposition that a conflict between the desires of the individual and the needs of the service come in sharp focus. The medical officer is constantly confronted with the problem of evaluating symptoms. Do the complaints of the soldier warrant hospitalization or, if hospitalized, further evacuation for more investigation? Is the patient recovered and ready for full duty despite subject symptoms; should he be recommended for non-combat duty; or is the condition so severe that he should be evacuated to the ZI? It can be readily understood that medical decisions are of vital importance to the soldier, for his comfort, security, and even life depend on the practical implication inherent in the medical opinion. Literally, the medical officer is in a position to open or close the door of the honorable medical escape from the uncomfortable and often hazardous obligations of the soldier.

Admittedly, this places the young medical officer in a difficult emotional position. If his examination indicates a definite clinical disability which coincides with the desires of the soldier to be hospitalized or evacuated, there is no problem. But when secure clinical evidence is lacking and the individual insists that he is unable to do duty, a literal doctor's dilemma is present. It is human to identify with others, to emotionally feel their plight and allow this mechanism to subconsciously influence one's decision. Moreover, the medical officer stationed in hospitals and other rear areas can readi-

ly develop a feeling of guilt when his decision causes the discharge of a patient to a hazardous environment which, fortunately, the doctor does not have to endure.

The difficult problem of how to separate the "I can't's" from the "I won't's" can only be resolved if the medical officer utilizes to the fullest his technical ability. He must refrain from considering himself in the omnipotent role of being personally responsible for the ultimate fate of the patient once his medical responsibilities are accomplished. The return of patients to a duty status is a function of command. Regardless of where the medical officer is stationed, his function is clear and unequivocal. Patients must be reasonably examined and evaluated. If the individual is disabled for duty and requires further treatment not possible at the particular time or level in which he is operating, then medical evacuation is indicated. But if the soldier has no objective findings and only subjective complaints, he is not disabled and must be promptly and firmly returned to his unit. Acrimonious disputes with the patient and long explanations are of little value. Becoming angry at the patient or tearful with him does not help anyone. The soldier should not be told to "try it again and see your battalion surgeon if you have any trouble," because this implies doubt on the part of the medical officer and confirms the patient's belief that his symptoms are valid. In most instances the medical officer can trust his clinical judgment. Unnecessary and elaborate diagnostic surveys serve only the purpose of allaying the anxiety of the doctor when he tries to disprove all of the patient's symptoms. If there is a reasonable doubt in the mind of the medical officer, diagnostic procedures are indicated and valid, but this should be a clinical impression and not stem from the emotional insecurity of the medical officer. It is only by the use of a fair, reasonable and objective clinical approach that the medical officer can best perform his role in what is admittedly a difficult time for all. The unwillingness of a soldier to return to combat duty is quite understandable but this is not a professional matter for the doctor to enforce. It is pertinent to reiterate that the medical officer is not actually the arbiter of the fate or destiny of the soldier. He is only a technical expert whose function is the evaluation, management, and treatment of disabilities resulting from mental and physical disease or injury.

Turning to the purely psychiatric breakdowns which occur in combat, we have designated these cases as "combat exhaustion." This term is utilized exclusively in the divisional area in order to give the connotation that the acute combat psychiatric casualty is a transient and fluid condition and not a fixed neurosis. It also indicates that the lowering of the psychological state of the body by fatigue, loss of sleep or food, or intercurrent illness, acts as a precipitating agent in decreasing the ability of the individual to withstand the effects of battle stress.

Treatment must be given as far forward as possible in order to prevent a gain in illness from causing a fixation of symptoms. Three levels of psychiatric treatment are in current operation. The first, at the division level, is conducted by the division psychiatrist at the clearing station. Approximately 50% of the patients are returned to combat duty. The

remainder are evacuated to the second echelon of treatment located in hospitals in Eighth Army. More prolonged therapy procedures such as barbiturate interviews and hypnosis are utilized. This echelon of treatment returns approximately two-thirds of its received patients to duty of a combat or noncombat type. The most severe patients are evacuated to Japan where three neuropsychiatric centers are located near air evacuation centers. They are equipped with electroshock, EEG, and other facilities which enable them to handle any type of neuropsychiatric patient. The majority of even such patients can be salvaged for noncombat duty.

Last, but not least, a reference to the emotional reaction of the medical officer is in order. Like others who are overseas and in the combat zone, he undergoes privations and discomforts. This is seldom verbalized directly because the doctor does not wish or expect to be considered as a superior human being who is immune from the sacrifices demanded of other citizens. Instead, some medical officers are prone to rationalizations that their professional talents are being wasted or that they are not being utilized to the best interests of the service. There may be occasions when such accusations are true. There is no doubt that the divisional medical officers cannot always employ their medical abilities to the fullest extent but the morale factor of having doctors near combat troops is of vast importance. There may be occasions when aid station and hospital admissions are low. This results in the medical officers having more leisure time so that they can justifiably state that their services are not particularly needed and they should be sent home. But the casualty rate depends on the tactical situation, future operations are unpredictable, and medical facilities must be available to handle the inevitable ebb and flow of battle casualties. Some have complained that professional work in rear hospitals is monotonous.

There are too few major operations to perform and much time is spent in the repair and treatment of minor wounds. This is regrettable but the clinical material received from battle is the result of enemy action and outside the sphere of influence. Some doctors are stationed in dispensaries with less opportunity for definitive care of complicated cases. Every effort is made to rotate such assignments consistent with the overall needs and the availability of medical personnel. Pediatricians and obstetricians cannot be utilized to the same degree as in civilian life, but efforts are made to assign them to the nearest specialty such as surgery or internal medicine.

It would be erroneous to assume from what has been stated that little opportunity exists in this command for professional work and for the betterment of professional ability. The contrary is closer to the experience of the majority of the currently assigned medical officers in the Far East Command. Most of the young surgeons, internists, psychiatrists, and other specialists have had an unparalleled opportunity to practice in their fields and increase their skill and knowledge, although at times they have worked quite hard and under difficult circumstances. There are other gains for the medical officer, perhaps not as tangible as professional work, but of equal benefit in the maturing process of an individual. The medical officer learns to increase his initiative, to utilize his resourcefulness, and to assume greater responsibilities than heretofore. His varied duties enable him to see the world more objectively than from the previous secluded viewpoint of his specialized world. The associations and friendships formed during his wartime experience are fruitful and enduring. The sum total of these experiences tends toward an enrichment of character and a more realistic concept of human behavior which will stand him in good stead in his future.



CHANCROID

Lt Col Louis N. Altshuler, MC, Assistant Preventive Medicine Officer, Medical Section, Eighth Army

Chancroid is of military significance because of the high rate in Korea and the fact that it may be the site of development of a primary lesion of syphilis. Chancroid, "ulcus molle," or "soft chancre," is an acute localized autoinoculable disease caused by the *Hemophilus ducreyi*. It is a disease of filth and poor hygiene. The local genital lesion is

a non-indurated tender ulcer with an incubation period averaging three to five days. The ulcers are irregular, present a granular dirty-grayish base covered with small amount of purulent exudate with slight undermining at the edges. Free bleeding follows manipulation. The ulcers are more frequently multiple than single and tend, because of their auto-inoculability to become more numerous as the disease progresses. The commonest location is at the edge of the phimotic prepuce.

Chancroid is less likely in the circumcised because

of the physical and histologic changes that occur on the distal end of the penis after circumcision. The skin of the glans, corona, frenulum and inner portion of the prepuce in the uncircumcised is more like mucous membrane, being soft, moist and easily traumatized during love play and coitus, with resulting microscopic and macroscopic tears. The skin of the corona, glans, frenulum and distal portion of the shaft in the circumcised is tough, keratinized, dry and a degree or more cooler than is the area under the prepuce of the uncircumcised. The prepuce, especially when it is phimotic, acts as a sheath holding bacteria acquired during coitus, is an excellent moist, warm culture medium, making infection likely through the tears mentioned. The opposite is true of the dry, cool, tough skin of the circumcised. Chancroid is much more frequent in men than in women although it has been shown that the lower class female in the orient is an asymptomatic carrier of this disease. It has been suggested by Brams that this organism may be found in some males as a saprophyte in the smegma of the coronal sulcus. Most annoying complication of chancroid, the suppurating bubo, is usually unilateral, fluctuant, and ruptures spontaneously. Extensive ulceration or spontaneous healing may follow such rupture. Rauschkolb studying the factors leading to the development of the bubo formulated the following axioms:

- a. The smaller the ulcer and the more inaccessible to therapy, the more likely the occurrence of bubo.
- b. Conversely the larger and more accessible, the less the incidence of bubo.
- c. Caustics or actual cautery predispose to the development of adenitis.
- d. Lesions so situated as to produce phimosis and poor drainage are more apt to initiate adenitis.

Induration is not characteristic of the chancre in the male and female and its spontaneous appearance should always arouse suspicion of a double infection with syphilis.

SYMPTOMS: The disease begins as an inflammatory macule which rapidly becomes a papule and then pustule. The pustule ruptures early with the formation of a ragged ulcer which lacks the induration of a chancre, usually being soft with an indefinite, inflammatory thickening. The base is covered by a purulent, necrotic, grayish exudate. Pain and tenderness are prominent symptoms. The following clinical varieties are recognized:

- a. A single lesion of typical character.
- b. Multiple ulcerations.
- c. Transient chancre, or "chancre mou-volant", consisting of small, superficial ulcerations which undergo spontaneous evolution without scar formation in four to six days. Such lesions account for many cases of inguinal adenitis that occur several weeks later without demonstrable genital lesions and are confused with lymphogranuloma venereum.
- d. Hypertrophic type with exuberant granulations above the surface, or the "ulcus molle elevatum."
- e. Small crateriform ulcers arising at the site of the follicles often in large numbers commonly known as follicular or military chancre.
- f. Phagedenic type or the "ulcus molle gangrenosa," a rapidly destructive type.
- g. The giant chancre characterized by unusual size.
- h. Serpiginous chancre is a chronic type characterized by serpiginous-ulcerous peripheral extension. It starts from a bubo in the inguinal region and gradually spreads to the lower abdomen, the thigh and buttocks.
- i. Extragenital chancre is not as rare an occurrence as is supposed. Lesions have occurred on all parts of the body, including mouth, eyelids, fingers, breasts, from abnormal sex practice and autoinoculation.

DIAGNOSIS: The current diagnosis of chancre is important and at times difficult. There is tendency to call so-called abrasions or hair outs, (when dark-field negative), chancre, in order to place the individual under treatment. Microscopic examination of smears cannot be depended upon exclusively because of the presence of other non-specific organisms. In some instances a few morphological or tinctorial bacterial types are found. On the other hand, dirty secondarily infected ulcers occur with concomitant multiform flora, and an opinion based on microscopic examination is of questionable value except as it suffices to rule out

granuloma inguinale.

The diagnosis of chancre is too commonly made on clinical evidence and response to therapy. The possibility of a mixed infection with syphilis should never be overlooked. The dictum that every genital lesion

should be suspected of being syphilitic until proved otherwise by repeated darkfield examination, and serologic follow-up should be strongly adhered to. Individuals with chancre or penile ulcers, should have an STS at least once weekly for the first month and monthly thereafter for five months unless the diagnosis is made earlier. This serologic follow-up is as integral to the airtight exclusion of syphilis from the diagnosis of chancre as it is to the exclusion of syphilis as a complication of gonorrhea. Syphilis and chancre are frequently acquired from a single exposure resulting in mixed infection. Chancre with its shorter incubation period appears first, and although a diagnosis of chancre is warranted, the possibility of a co-existing primary syphilitic infection must be considered and the patient be kept under close observation.

Diagnosis of chancre is aided by one or more of following methods: Intradermal (Reaction (Ito-Reensteirna Reaction), Biopsy, Smears, Culture, Auto-inoculation, and Exclusion.

a. Intradermal Reaction (Ito-Reensteirna Reaction). Greenblatt and Sanderson have called attention to a very valuable method of including or excluding chancroidal infection. They have originated an intradermal test for chancroidal infection using an antigen made from a saline suspension of the Ducrey bacillus. A positive Ito skin reaction is only presumptive evidence and does not necessarily mean the lesion under consideration is chancroidal. A similar conclusion should be borne in mind in the interpretation of serologic tests for syphilis as well as a positive Ito Reaction. A repeatedly negative reaction carried out over a period of three weeks rules out chancroid. A positive intradermal chancroidal test commits one to the diagnosis of chancroidal infection only when the STS and darkfield examination for T. Pallida are negative. Its specificity has been estimated by Greenblatt and Sanderson to be between 90 to 100%.

- (1) **Technique:** The intradermal Ito test is the most readily available diagnostic procedure now that a commercial bacillary vaccine is marketed by the Lederle Laboratories. This antigen is now available in this command as Item "NS-1 Ducrey Vaccine Diagnostic." It is supplied in 5cc vials sufficient for 50 skin tests. The test is performed by injecting 0.1cc of the vaccine intradermally on the cleansed flexor surface of the forearm.
- (2) **Results:** Sensitivity to the intradermal injection may ensue as early as 10 to 14 days following infection with Ducrey's organism. Maximal intensity of the reaction usually occurs 48 hours after the injection of the vaccine and the results should be observed at the end of this interval. Very rarely the reaction may be delayed until 72 hours. A positive reaction is manifested by an area of induration surrounded by an erythematous halo at the site of injection. The induration should measure 7 mm in diameter in positive cases. Occasionally the induration may be minimal, and in such cases the erythema must measure 14 mm before the reaction may be considered positive. Any smaller reaction is a doubt-

ful test and should be repeated after several days.

(3) Interpretation:

(a) A positive Ito Skin Reaction cannot be relied upon absolutely to establish the chancroidal nature of any clinical condition since it is known that in untreated infections with H. ducreyi skin sensitivity persists for a long time.

(b) A positive test may, therefore, mean only that the patient has had chancroid at some time in the past, rather than that his present symptoms are caused by the H. ducreyi. A careful history may elicit this information.

(c) A diagnosis of chancroid should not be made on the basis of a positive Ito Skin Reaction in the absence of clinical symptoms.

(d) Repeated negative Ito Skin Reactions in the presence of a clinically suspicious lesion of at least 10 days duration is of value in excluding the diagnosis of chancroid.

b. Biopsy: According to Hayman, Beeson and Sheldon, this is an accurate method of diagnosis. Unfortunately, it requires the services of a well-trained pathologist and is not practicable on a dispensary status.

c. Smear: The Gram, Unna-Papanheim, Wright or Giemsa stain is used. The Ducrey bacilli show a tendency to bipolar staining which gives some of them the "closed safety pin" appearance. Greenblatt and others have stressed the "schools of fish" arrangement in which the bacillus are grouped in long parallel columns between the lymphocytes. In spite of these characteristics, the demonstration of H. ducreyi with diagnostic accuracy is questionable. Most reports returned from the laboratory have the following notations: "Organisms resembling H. ducreyi". This is very discouraging to the clinician as there is a possibility that the lesion may not be chancroid.

d. Culture: H. ducreyi has been cultured on suitable blood agar slants from bubo pus, aspirated under aseptic conditions. Efforts to culture this organism in the Far East Command have been disappointing. Material from the primary lesion is usually unsatisfactory because of contamination. This procedure is extremely difficult and is recommended only in exceptional cases.

e. Autoinoculation: Some material obtained from the lesion is rubbed into a previously scarified area. In two or three days small vesicopustules appear at the site of inoculation. These break down to form typical chancroidal ulcerations. The Ducrey bacillus can usually be obtained much more readily from such lesions by smears or cultures. This procedure is not recommended as it has the same pitfalls as that of the original lesion.

f. Exclusion: A diagnosis of chancroid may be accepted if repeated search for T. pallidum, Frei and serologic test for syphilis are negative, and the clinical and historical evidence are positive.

TREATMENT:

Systemic: We have noticed with great concern that although the sulfonamides are generally considered

to be almost specific in the treatment of chancroidal disease, a considerable portion of individuals failed to respond favorably to the sulfonamides or may be sensitive to them. This sensitivity may have developed by the widespread use of the sulfonamides for other conditions.

As a result of these considerations a search for an antibiotic which might be useful where the sulfonamides are inapplicable and would be used as an out-patient procedure was made. In vitro sensitivity determinations of penicillin, streptomycin, bacitracin, polymixin and aureomycin against 16 strains of H. ducreyi were studies by investigators in the United States. These strains were all isolated from patients with clinical chancroid and were identified by smear and culture. Ducrey or Ito skin test was performed in these patients, and in each case the reaction was positive. The results of these in vitro sensitivity studies demonstrated moderate sensitivity to streptomycin and aureomycin; penicillin, bacitracin exerted only a transient inhibitory effect. All strains were resistant to high levels of polymixin.

Based on these in vitro sensitivity studies, and the need for an antibiotic to replace the sulfonamides and could be administered as an out-patient procedure, clinical trials with streptomycin (Item No. 1-609-840) and aureomycin (Item No. 1-596-757) were instituted. Our experience with streptomycin covers 2,000 cases carefully studied and followed. The dosage used was 1 gram daily intramuscularly for 3 to 5 days. The results were above our expectations. The procedure was to give no treatment until a minimum of three darkfields had been accomplished and the possibility of syphilis excluded. Treatment was withheld as little is known of the treponemocidal effect of streptomycin*, and we did not want to do anything that would interfere with making the diagnosis of syphilis. To sum up our experience with streptomycin we found that the days of treatment were reduced from 14-24 days (sulfonamides) to 3-5 days (streptomycin). It was also interesting to note that the incidence of the complicating bubo was decreased from 50 to 60% (sulfonamides) to 10 to 15% with streptomycin. In streptomycin treated groups there were no evidence of streptomycin toxicity.

Due to the critical shortage of aureomycin and the high cost, we were only able to treat 300 individuals with aureomycin. Treatment was withheld until the possibility of syphilis was ruled out. A priming dose of 2 grams of aureomycin was given followed by .5 grams every 6 hours for 3 days. Some mild gastrointestinal upsets were noticed, however, this was prevented to some extent by the administration of Triasyn B Tablets (Item No. 1-488-700) one tablet three times daily. The therapeutic results with aureomycin were as good if not a little more effective than those treated with streptomycin. However,

* There is increasing evidence to indicate that streptomycin has little or no treponemocidal effect. Patients with positive darkfields have been given 1 gram streptomycin for five days. Darkfield examination was repeated each day and found to be positive. This opens up a new approach since it may be possible for individuals with mixed infections to be placed under treatment for chancroid while under observation for syphilis. However, this procedure is not recommended at this time due to the small number of cases observed.

aureomycin has the following deficiencies when observed from the standpoint of military out-patient practice:

- a. High cost
- b. Critical shortage
- c. Patient must be given sufficient capsules for 3 days treatment and there is no assurance that he will take his medication. This is particularly true in Korea where aureomycin is a black market item.
- d. Mild gastrointestinal upsets were noted.

Streptomycin is recommended because of:

- a. Low cost
- b. Ready availability
- c. Patient can be given all his treatment on an out-patient status and the human element is eliminated.
- d. No untoward symptoms noted in small dosages of streptomycin required.

Local Treatment: Local treatment consists of cleanliness with soapy water and the local application of a mild antiseptic such as Zephiran (Benzalkonium) chloride (Item No. 1-498-705)(1:100) or $KMnO_4$ soaks 1:10,000.

A good out-patient procedure is to give patient a small bottle of Hydrogen Peroxide 3% to use after washing the lesion with soap and water. In addition, a local application of Bacitracin ointment or 3% aureomycin in a hydrophilic ointment base (Item No. 1-229-675) should be applied daily to the lesion at the dispensary. In our hands the use of aureomycin or bacitracin ointment is superior to any other local treatment. It must be emphasized that no local treatment should be employed with the exception of normal saline soaks until the possibility of syphilis has been excluded.

Management of Bubo: The bubo should not be incised.

If fluctuation is present it should be aspirated with aseptic care using a 16 gauge needle. Aureomycin or bacitracin ointment may be applied to the puncture wound and a pressure bandage applied. Repeat aspiration if indicated. Ulceration should not occur if the patient is properly observed.

Phimosis: Marked phimosis should be treated by irrigation with potassium permanganate for cleansing purposes followed by insufflation with zinc peroxide dusting powder (Item No. 1-502-700). Circumcision is recommended after healing of lesions for chronic repeaters.

Comment: An attempt has been made to offer some suggestions in the management of chancroid based on clinical experiences in medical installations of the Eighth Army, both while in Japan and Korea.

CONCLUSIONS:

- a. Diagnosis of chancroid should be made on the basis of exclusion.
- b. A diagnosis of chancroid may be accepted if the signs and symptoms are typical, the smear and Ito Skin Test negative, and repeated darkfield examinations for T. pallida and STS are negative.
- c. Repeated negative Ito Skin Test excludes the diagnosis of chancroid.
- d. Streptomycin and aureomycin are the antibiotics of choice in the management of chancroid.
- e. Streptomycin in daily 1 gram doses intramuscularly for 3-5 days is the antibiotic of choice for the out-patient management of military patients.
- f. Fluctuating bubo should be aspirated and not incised.
- g. Serologic follow-up should be accomplished at least once weekly for the first month and monthly thereafter for five months unless the diagnosis of syphilis is made earlier.



NOTES ON DENTAL MATERIALS

Colonel Harold G. Ott, DC, Dental Surgeon, GHQ, FEC

As stated in the June issue, these notes are a resume of progress reports on several dental research projects being supported by the Department of the Army. Final conclusions and publication of results must await further work in the various fields of investigation.

by various combinations of wet and dry asbestos liners, both immersed and sealed, and with and without silica gel.

Data provided by these tests undoubtedly will result in better control of investment expansion and improve casting techniques.

Similar setting expansion experiments were conducted on hydrocol to determine the effect of the addition of various inert materials such as pumice, graphite, talc, and silica gel. In general the greatest degree of expansion occurred in the hydrocol-silica gel mixture.

DENTAL INVESTMENTS:

Studies were made of factors affecting the setting expansion of inlay investments. Well-known brands of commercial investments were subjected to numerous test conditions and it was determined that the normal setting expansion of approximately .3% in each of those tested could be increased to as much as 5.4% in some cases by the addition of 20% silica gel. Numerous intermediate degrees of expansion were achieved

DENTAL INSTRUMENTATION:

Tests to determine the most efficient operating conditions for dental burs and diamond points are in progress. Results to date indicate that temperatures

attained by the rotating dental bur do not increase in direct proportion to the speed of rotation. This rise tends to become stabilized at a certain speed and the time required to penetrate test materials to fixed depths likewise tends to become constant beyond a certain speed. Correlation of these data will provide optimum operating criteria so that maximum cutting efficiency and minimum heat production can be attained.

MISCELLANEOUS:

Work on the revision of specifications and the testing and evaluation of various dental products of interest to the Federal dental services are constantly in progress. Among these items are denture base material, boxing wax, silicate cement liquid, amalgamators, sterilizers and several types of hand instruments.



BRANCHIAL CLEFT CYST: A CASE REPORT

Captain Charles L. Lynch, MC, Chief of Surgical Service, 172d Sta Hosp, APO 547

This 25-year old white female dependent stated that she was well until 7 months ago when, while 3 months pregnant, she first noted a walnut sized mass in her right upper neck, beneath the angle of the jaw. It was non-tender and non-painful, and did not change in size throughout the rest of her pregnancy.

At term, the patient developed a primary inertia after 36 hours of labor and an emergency Caesarean Section had to be performed, 11 hours after the membranes had ruptured. Fetal malposition appeared to be the primary cause for this eventuality.

While the patient was under anesthesia, the anesthesiologist called attention to a mass on the right side of the patient's neck about the size of a lemon, which felt cystic. In about 10 days, the patient had recovered from a rather stormy postoperative course and was discharged from the hospital, improved, with an incidental note being made that the neck mass had increased about 2 c.m. in its greatest diameter since the time of operation. This was still asymptomatic however. The patient returned to the outpatient clinic one week after discharge for a post-operative check-up. By this time, the neck mass had enlarged to the size of a peach, was tense, and was giving her some pressure symptoms. It was becoming difficult for her to swallow. She was seen by the Surgeon at this time.

The mass was definitely cystic and tense and transilluminated. It extended upward behind the angle of the jaw, downward to the level of the hyoid, anteriorly half way along the inferior border of the mandible and posteriorly seemed to overlap the anterior border of the sternocleidomastoid muscle. The patient was allowed to go home for another week. When she returned the next time, her dysphagia was more marked and she complained of actual pain from the pressure of the mass against the side of her neck and pharynx. The mass was now approximately the size of an orange and bulged from her right upper neck from the level of her ear lobe to the level of the thyroid cartilage. By this time, the mass was very tense and still cystic, and it still transilluminated. It was tender to firm palpation, but there was no sign of active induration or inflammation. Patient was admitted to the hospital on this day, and the cyst was aspirated, with a size #20 needle, 6 cc of opaque milky fluid being obtained. Four cc of lipiodol were instilled into the cyst

through this same needle and x-rays were taken. The aspirated fluid revealed no growth on culture. On microscopy, it was loaded with squamous epithelial cells and cholesterol crystals. X-rays taken one hour after the instillation of lipiodol revealed an indefinite cystic mass of the above mentioned dimensions. Repeat x-rays, the next day, revealed the same cystic mass, but there were also two streaks of radiopaque material coursing upward and posteriorly toward the middle ear, for a distance of approximately $1\frac{1}{2}$ inch each. These streaks measured approximately $\frac{3}{8}$ of an inch in diameter. At the same time, there was another string-like streak of radiopaque material coursing downward from the mass to the upper border of the superior mediastinum. This latter was interpreted as merely leakage along a cervical fascial plane. Four days later under endotracheal anesthesia, the following procedure was done:

Under endotracheal general anesthesia, an incision was made over the area of the cyst. Anterior and posterior skin flaps, together with the subcutaneous fat were raised. The platysma was then incised and was reflected as a separate layer. The enveloping layer of the deep cervical fascia was incised vertically at the level of the carotid sinus just anterior to the anterior border of the sternomastoid muscle. This revealed the lower pole of the underlying cystic mass. A cleavage plane was easily found and the cystic mass was separated from the surrounding structures by blunt dissection and pledgets. In doing so, the following structures were exposed in the following relation to the cyst: laterally, sternomastoid muscle; medially, carotid sheath with its contents including the internal and external carotid arteries, the hypoglossal nerve descending branch of the hypoglossal, the internal jugular vein and the vagus nerve; posteriorly: the phrenic nerve the ascending pharyngeal artery, communicating branches to the descending branch of the hypoglossal nerve from the second and third cervical spinal nerves, the portion of previous vertebral deep cervical fascia lateral to the carotid sheath; inferiorly, carotid sinus and common carotid artery. The cyst was successfully dissected from all above mentioned structures without injury to them until it remained attached to the neck by means of a pedicle at its superior pole, which felt solid rather than cystic, but not hard. The superior pedicle was then traced upward and dissected free as it passed superficial to the thylohyoid and thylohyoidpharyngeal muscles but deep to external carotid. Superior to, and behind the angle of the mandible the cervical branch of the facial nerve was preserved, as well as the other branches. At this point, it was deemed advisable to discontinue any further upward dissection behind and deep to the angle of the mandible

through the present incision. The specimen was removed up to this point, leaving approximately 1/2 inch of soft, solid tissue, approximately 1/2 c.m. in diameter situated between the inner surface of the posterior border of the mandible and the anterior tubercle of the transverse process of the second cervical vertebra. The internal maxillary artery passed across its upper border. The external carotid artery passed superficial to it, and posteriorly, the inferior process of the parotid gland from which the internal jugular vein emanated. The carotid sheath was closed with interrupted sutures of #4-0 plain catgut. The enveloping layer of the deep cervical fascia was approximated with interrupted sutures of #4-0 plain catgut. The platysma muscle was then approximated by means of interrupted sutures of #4-0 plain catgut. The skin edges of the incisions were then approximated as a separate layer by means of interrupted Poole stitches of #6-0 silk. The wound was not drained. Good skin approximation was obtained. Patient returned to the ward in good condition. Blood loss during the procedure was negligible.

Patient made an excellent postoperative recovery. All sutures being removed on the fourth postoperative day, she was discharged home on the fifth, well-healed.

Pathological Report revealed findings consistent with a branchial cleft cyst, which contained lymphoid tissue in part of its wall. There was no evidence of malignancy.

CONCLUSION:

From a pathological point of view, the term branchial cleft cyst may well turn out to be a misnomer, as more is learned about the etiology of these tumors. The time-honored theory that they arise from

improper fusion of endoderm and ectoderm from the branchial pouches and clefts still leads in popularity in clinical circles. If this be true, then one could say that in this particular case, the cyst arose from the first cleft, namely, that between the mandibular and hyoid arches, as suggested by its position, and the fact that its pedicle coursed posteriorly toward the middle ear which is the point of junction between the first and second branchial arches. However, recent work suggests that this is not the whole story. Epithelial inclusions within lymph nodes have often been found in association with branchial cleft cysts. Not only this, but it has recently been stated that some part of the cyst wall will invariably contain lymphoid tissue. This suggests that branchial cleft cysts are somehow associated with maldevelopment of lymphoid tissue or the elements thereof. Such a hypothesis receives the added support of the findings in this case since the solid tissue pedicle, by which the cyst was attached superiorly, proved to be lymphoid tissue.

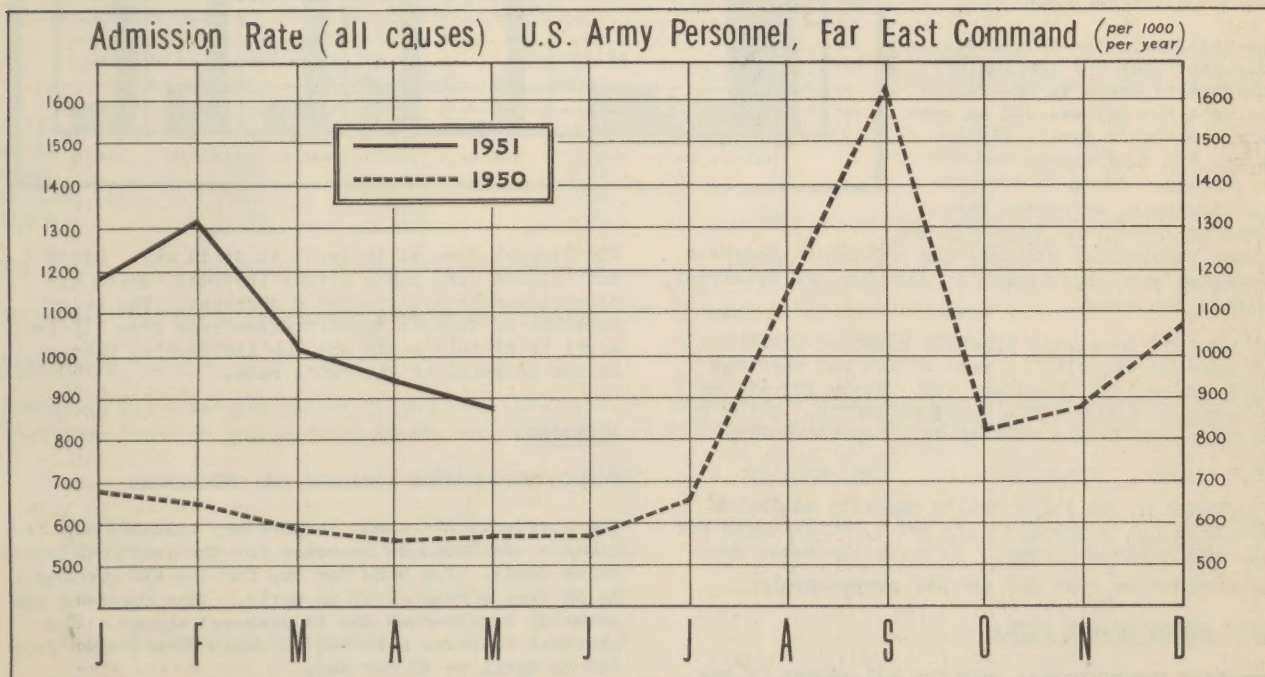
SUMMARY:

A proved case of branchial cleft cyst has been briefly described which suggests that such tumors spring from developmental aberrations involving lymphoid tissue, which are of mesodermal origin, as well as, or even rather than, from malfusion of endodermal and ectodermal elements.

REFERENCES:

1. King E.S.J.: Lateral Lymphoepithelial Cyst of Neck - Australian and New Zealand J. Surg. 19: 109-121, November 1949
2. Branchiogenic Anomalies - Ward, Hendrik and Chambers, West J. Surg. 57:536-549, November 1949

HEALTH OF ARMY TROOPS, FEC



Admission rates per 1,000 troops per annum, Army personnel, for the 5-week period ending 30 May 1951 were as follows:

	FEC	JAPAN	KOREA	MARBO	PHILCOM (AF)	RYCOM
All Causes	880	646	1006	278	348	787
Diseases	638	588	665	198	282	716
Injuries	121	58	154	80	66	70
Battle Casualties	121	0	187	0	0	.98
Psychiatric	24	9.9	31	14	0	14
Common Respiratory Diseases and Flu	68	90	61	42	41	9.3
Primary Atypical Pneumonia	3.0	3.7	2.6	0	0	4.9
Common Diarrhea	15	4.9	20	0	0	3.9
Bacillary Dysentery	.42	0	.45	0	8.3	2.9
Amebic Dysentery	.46	.42	.45	0	0	.98
Malaria, new	15	19	14	0	8.3	8.8
Infectious Hepatitis	15	7.4	19	14	8.3	6.9
Mycotic Dermatoses	2.9	5.4	1.4	0	0	0
Rheumatic Fever	.62	.95	.50	0	0	0
Venereal Diseases	131	144	122	0	50	219

DAILY NON-EFFECTIVE RATES

All Causes	35	87	13	9.4	53	15
Venereal Diseases	.07	.13	.05	0	0	.04

ALL CAUSES ADMISSION RATE:

The admission rate to medical treatment facilities and quarters for all causes for Army personnel in the FEC decreased to a rate of 880 per 1,000 strength per year in May from a rate of 955 for the previous month. The decline in the all causes admission rate is primarily the result of the notable decrease in the battle injury rate. For May this was 121 as compared to 177 for the previous month.

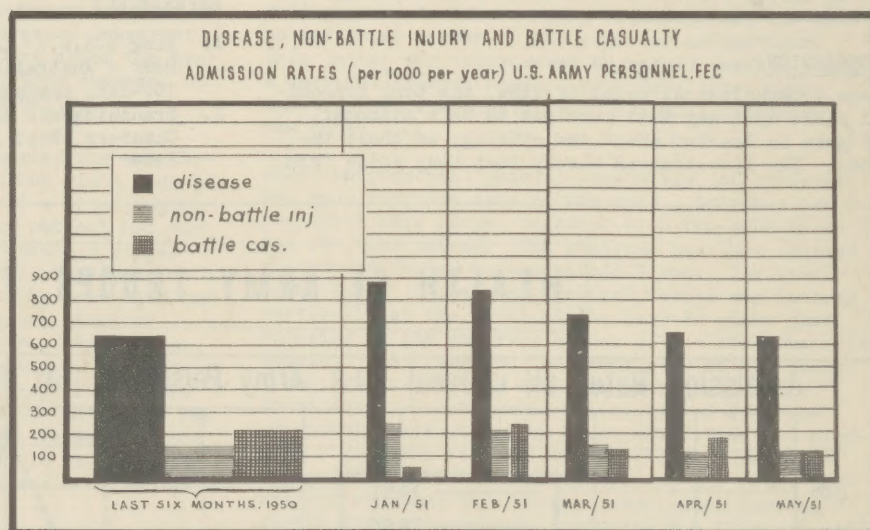
The incidence rate for disease only decreased for the fourth consecutive month in the FEC. The rate for May was 638 as compared to 656 in April, 729 in March, 850 in February and 886 in January. Among the reportable diseases, decreases were noted in infectious hepatitis and common respiratory diseases and influenza. Moderate increases were experienced in diarrhea and dysentery, malaria and mumps.

The rate for nonbattle injuries remained practically the same for the FEC. A rate of 121 was reported for May; that for April was 122. Rates for all major commands except RYCOM remained static. RYCOM reported a rise from a rate of 38 in April to 70 in May.

A decrease in the FEC's battle casualty admission rate from 177 in April to 121 per 1,000 strength per year was reported in May. In Korea the rates for the same period were 253 and 187 respectively.

DAILY NON-EFFECTIVE RATE:

The daily non-effective rate for all causes in the



FEC dropped from 41 in April to 35 in May. RYCOM and PHILCOM (AF) had a slight increase, while all other commands experienced a decrease. The great decrease of Japan's non-effective rate from 115 in April to 87 this month was the influencing factor in the decrease of the FEC's rate.

DISEASES:

COMMON RESPIRATORY DISEASES AND INFLUENZA:

The incidence of common respiratory diseases and influenza continued to decrease for the fourth consecutive month. The rate for May for the FEC dropped to 68 from a rate of 97 in April. This decrease can normally be expected due to seasonal change. The greatest decrease occurred in Japan with a drop from 146 in April to 90 for May.

RESTRICTED

PSYCHIATRIC:

Admissions for psychiatric conditions definitely decreased in the FEC from a rate of 32 for April to one of 24 for May. Both Japan and Korea shared in this lessened incidence of psychiatric admissions. Japan in particular decreased from a rate of 19 for April to a rate of 9.9 for May. The Japan decrease may be the result of the increase of strength by the newly arrived National Guard divisions. It is believed that the decrease from a rate of 38 in April to 31 in May for Korea, in part, may represent the favorable influence of rotation. The rotation plan has been in operation a sufficient length of time to remove from the command the veteran combat soldier who is a frequent source of psychiatric breakdown in battle.

MALARIA:

The rate for new malaria continued to rise in May. The rate for the FEC rose from 11 in April to 15 in May. The sharpest increase occurred in Japan and RYCOM where the rates rose from 8.4 to 19 and 1.2 to 8.8 respectively. Returnees from Korea contributed significantly to the increases in the Japan area. Korea's rate remained static at 14, while PHILCOM (AF) reported 1 new case; none occurred in MARBO.

DIARRHEA AND DYSENTERY:

The rate for intestinal diseases infections in Korea increased from 10 in April to 23 in May. This rate is not unusually high compared to past experience. Korea's increase was the primary cause of the rise in the rate for these diseases in the FEC. The rate for the FEC was 8.9 in April and 17 in May. Japan had a slight decrease, PHILCOM (AF) and RYCOM reported increases, while MARBO again reported no cases.

INFECTIOUS HEPATITIS:

A notable decrease is reflected in the infectious

HOSPITALIZATION:

The bed status as of 30 May 1951 was as follows: (These data cover all patients, Army, AR and others.)

	Bed Capacity		Operating		% Normal Bed	% of Operating
	Normal	Mobilization	Beds	Beds Occupd	Capacity Occupd.	Beds Occupd.
JAPAN	10,100	10,860	10,100	9,014	89	89
KOREA	3,500		3,500	2,390	68	68
MARBO	200	200	200	34	17	17
PHILCOM (AF)	250	250	143	72	29	50
RYCOM	250	300	250	290	116	116
FEC	14,300	11,610	14,193	11,780	82	83

In Korea, 10,846 operating beds were established for POW of which 8,099 were occupied.

EVACUATION

Tabulated below are the number of patients (all types of personnel) evacuated from the major commands to the ZI during the five report weeks in May and the number of patients awaiting evacuation as of 30 May 1951:

	JAPAN	MARBO	PHILCOM (AF)	RYCOM	FEC
By Air	1,715	5	9	70	1,799
By Water	179	0	3	7	189
Total	1,894*	5	12	77	1,988
Patients Awaiting Evacuation	60	0	0	0	60

(* 1,403 patients originated from Korea.)

hepatitis rates for the FEC. For May, the rate was reduced to 15 from the high rate of 26 for the previous month. This is the lowest rate for infectious hepatitis since the January rate of 16. The lower rate is primarily due to the decrease in the incidence of infectious hepatitis in Korea, which is the source of the majority of the cases in the FEC. Rates for the other commands remained static.

VENEREAL DISEASES:

The venereal disease rate in the FEC decreased from 136 in April to 131 in May. MARBO again reported no cases. Japan and RYCOM showed notable decreases. Japan's rate decreased from 185 in April to 144 in May, and RYCOM from 246 to 219. The rate for Korea increased from 115 in April to 122 in May, and PHILCOM (AF) increased from 20 in April to 50 this month.

SMALLPOX:

Among United States Army personnel of the FEC only one case of smallpox was reported in May. This case occurred in Korea.

MEASLES:

During May, there were 247 cases of measles reported, an increase of 26 cases. Of these cases, 216 were reported from Japan, and occurred chiefly among troops recently arriving from the United States. An even higher incidence rate for German measles (rubella) is reflected for May, Japan being the source of 269 of the total 280 cases reported.

DEATHS:

During the 5 weeks covered in the May report, a total of 147 deaths was reported by medical treatment facilities in the FEC. 95 deaths occurred among battle casualties, 14 among diseases and 38 among nonbattle injuries.

RESTRICTED



The Chief Surgeon extends an invitation to all Far East Command medical personnel of the U. S. Army, Navy and Air Force, or of the United Nations, to prepare and forward with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted unless author states otherwise.

Lt. John J. Griffin, Editor